



# THE UNIVERSITY *of* EDINBURGH

This thesis has been submitted in fulfilment of the requirements for a postgraduate degree (e.g. PhD, MPhil, DClinPsychol) at the University of Edinburgh. Please note the following terms and conditions of use:

This work is protected by copyright and other intellectual property rights, which are retained by the thesis author, unless otherwise stated.

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge.

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author.

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given.

# **An investigation of shame in forensic populations**

Emma Abigail Macey



THE UNIVERSITY  
*of* EDINBURGH

Doctorate in Clinical Psychology

University of Edinburgh May 2017

## DClinPsychol Declaration of Own Work

**Name:** Emma Abigail Macey

**Title of work:** An investigation of shame in forensic populations

*I confirm that this work is my own except where indicated, and that I have:*

- Read and understood the Plagiarism Rules and Regulations
- Composed and undertaken the work myself
- Clearly referenced/listed all sources as appropriate
- Referenced and put in inverted commas any quoted text of more than three words (from books, web, etc.)
- Given the sources of all pictures, data etc. that are not my own
- Not made undue use of essay(s) of any other student(s), either past or present (or where used, this has been referenced appropriately)
- Not sought or used the help of any external professional agencies for the work (or where used, this has been referenced appropriately)
- Not submitted the work for any other degree or professional qualification except as specified
- Acknowledged in appropriate places any help that I have received from others (e.g. fellow students, technicians, statisticians, external sources)
- Complied with other plagiarism criteria specified in the Programme Handbook
- I understand that any false claim for this work will be penalised in accordance with the University regulations
- Received ethical approval from the School of Health in Social Science, University of Edinburgh      OR
- Received ethical approval from an approved external body and registered this application and confirmation of approval with the School of Health in Social Science's Ethical Committee

**Signature** .....

**Date:**

## **Abstract**

It has been highlighted that shame may be an important dynamic risk factor for prevention of violence and recidivism in forensic populations. However, past research investigating the relationship between shame and violence, or recidivism has been inconsistent. Different conceptualisations and measurements of shame used in the literature may explain these inconsistencies. Therefore, a systematic review was conducted to explore how shame was conceptualised in forensic populations and these measures were then evaluated. Findings revealed that most studies did not clearly define shame, and when they did, the same theoretical underpinnings were used in different ways. By assessing the validity and reliability of shame measures, it was revealed that different measures focused on different aspects of shame. This could explain the current confusion in the conceptualisation and measurement of shame in forensic populations, and shed light on inconsistent findings between shame and other constructs.

Shame in violent female offenders is an unexplored phenomenon and therefore may involve various complex and unexpected factors. A social constructivist grounded theory approach was applied to the narratives of eight violent female offenders, focusing on thoughts, feelings and life experiences in relation to shame and violence. A model was constructed suggesting that childhood victimisation, in the absence of available, compassionate, secure relationships, may lead to difficulties with emotion regulation. The experience of negative emotions, including shame, may lead to self-harm, substance misuse and violence. It was however demonstrated that this vicious cycle could be broken through the

development of secure, positive and compassionate relationships. These findings suggest that shame and attachment may be important factors for treatment and service planning, to meet the unique needs of female offenders.

## **Dedication**

*To Ali thanks for the tea, encouragement, noodles, spontaneous trips to North Berwick and for convincing me that berocca's are not a substitute for healthy food even when in crisis. I mostly want to thank you for believing in me. Here's to a life that is out of the ordinary and a future that is full of adventure!*

## **Acknowledgements**

The only way I can describe this project is through Tchaikovsky's Russian dance, a firm favorite when I was eight years old. I used to leap around to this song in my living room with my sister and best friend constantly falling over but always getting back up again. The project has been full of ups and downs but has also been one of the most rewarding and challenging projects I have ever completed. This would not have been possible without the support of Ali, Kedzie, my supervisors, colleagues, friends and family.

I would firstly like to thank my academic supervisors, Ethel Quayle and Emily Newman, whose help, support and encouragement has been invaluable. My sincerest thank you to my clinical supervisor Mette Kreis whose enthusiasm, expertise and guidance will never be forgotten.

I would also like to say a big thank you to all the clinicians involved in this project who have helped me every step of the way.

Lastly, I would like to say thank you to all the participants who shared their life experiences with me. I feel extremely privileged for their honesty and kindness and this thesis would not have been possible without them.

# Contents

Thesis abstract .....	P. 3
Systematic review .....	P.8
Systematic review references .....	P.51
Systematic review appendices .....	P.60
Empirical study .....	P.67
Empirical study references.....	P.94
Empirical study appendices .....	P.104
Full thesis references .....	P.138



**A systematic review exploring constructs and measures of shame in forensic populations and how this relates with anger and recidivism**

Emma Macey, NHS Forth Valley, Forensic Clinical Psychology Service & University of Edinburgh, Scotland, Department of Clinical Psychology.

Emily Newman, University of Edinburgh, Scotland, Department of Clinical Psychology.

Ethel Quayle, University of Edinburgh, Scotland, Department of Clinical Psychology.

Mette Kreis, NHS Forth Valley, Forensic Clinical Psychology Service.

Corresponding author: Emma Macey, NHS Forth Valley, Forensic Clinical Psychology Service, Westburn building, Falkirk Community Hospital, Westburn Avenue, Falkirk, FK1 5SU. Tel: 01324 616211 Email: emma.macey@nhs.net

As prepared for The International Journal of Forensic Mental Health (see Appendix A)

10,426 words

## **Abstract**

The current study aimed to systematically review constructs of shame used in forensic populations and then to provide an initial evaluation of these measures. As part of the study, Medline, Embase and Psycinfo were searched to identify all measures of shame used in forensic populations. Twenty-two articles met the inclusion criteria and across these studies shame was either defined inconsistently, or not at all. Across these 22 studies, 10 measures of shame were identified. Measures were assessed through investigation of their validity and reliability. Results revealed that diversity existed across measurements of shame. Measures fell into two categories: state shame and trait shame, with each appearing to measure two different concepts. The results highlighted the importance of a clear conceptualisation of shame, and that researchers should aim to explicitly define shame before embarking on empirical research measuring shame. This will ensure researchers can differentiate between aspects of shame and investigate valid and reliable relationships with other psychological concepts or outcomes, such as anger, violence or recidivism.

**Keywords: Shame, Measure, Offender, Forensic, Constructs**

The first person to distinguish between the moral emotions of shame and guilt was Lewis, who suggested that guilt focuses on a negative evaluation of a specific behaviour and shame a negative evaluation of the global self. The emphasis on the self that is elicited by shame can lead to intra-psychic pain because the individual's core self is at stake (Lewis, 1971). This conceptualisation proposes that shame focuses on a negative evaluation of the global self, whereas guilt focuses on a negative feeling regarding the event or act. Lewis states that shame arises in the context of self-other comparisons, which results in a negative evaluation of the self, such as feeling powerless, worthless or inferior. It is suggested that this self-other comparison can be elicited by a real or imagined audience, leading to a sense of exposure in the self and a desire to escape or hide. Within the existing forensic literature, most studies using forensic populations have adopted the conceptualisation of shame presented by Lewis (1971). For the purposes of the current review, forensic populations will include all individuals currently or previously residing in a forensic mental health hospital or prison, or individuals previously convicted of a crime living in the community.

In agreement with Lewis (1971), Tangney and colleagues (Stuewig, Tangney, Heigel, Harty & McCloskey, 2010; Tagney, Stuewig, Mashek & Hastings, 2011) suggest that shame is concerned with the self being 'bad' (e.g. 'how could *I* have done that?') whereas guilt is concerned with a specific behaviour being bad (e.g. 'how could I have *done that*?'). They expand on Lewis (1971) by suggesting that shame is maladaptive, leading to avoidance or escape, whereas guilt is perceived

as a helpful, moral emotion, which leads to reparative behaviour (Tangney et al., 2011). This conceptualisation of shame is in direct conflict with the constructionist approach of shame suggesting that shame can be helpful under the right circumstances leading to co-operation, prosocial behaviour and self-improvement (Leach & Cidam, 2015). It may be that shame is unhelpful when coupled with avoidance and this pairing may commonly occur in forensic populations. However, viewing shame as always negative seems limited, especially considering that emotions are conceptualised as feelings and not by the behaviours that frequently arise with them. Another conceptualisation that draws on Lewis' (1971) shame concept is Gilbert's evolutionary model of shame and guilt (Gilbert, 1992). This model suggests that shame has an adaptive function for the survival of humans. Here, Gilbert (1992) states that shame is an evolutionary mechanism that alerts us to threats to our social status. In response to this threat, it is proposed that there are three potential responses: to submit and avoid, confront and attack or engage in socially desirable behaviours.

Both Tangney et al.'s (2011) and Gilbert's (1992) conceptualisations draw on Lewis' definition of shame, suggesting it to be a social construct perceived through the eyes of others. However, different parts of Lewis' conceptualisation have been used by the authors independently, to create separate measures of shame. Tangney, et al., (2011) suggests that shame is always unhelpful, leading to withdrawal and hiding, whereas Gilbert (1992) indicates that this is only one of three potential outcomes. This could arguably result in confusion in the literature, in that aspects of the same precedent conceptualisation are being interpreted in very different ways,

with the theoretical underpinnings of the definitions being interchangeably used without consideration.

Additionally, Gilbert (1997) goes further than Lewis (1971) by differentiating between internal and external shame. Internal shame is described as seeing the self as worthless or flawed, whereas external shame is how the self perceives what others see of the self, for example the self is perceived by others as an object of ridicule. Gilbert created a measure, the Other as Shamer Scale (OAS; Allan, Gilbert & Goss, 1994; Goss, Gilbert & Allan, 1994) dealing only with one specific aspect of shame, external shame. This measure used questions that focused only on negative appraisals of the self in the eyes of others, it was only concerned with a single aspect of shame. This example illustrates how important it is to not only disentangle how shame is defined, but also to determine the aspect of shame the literature is measuring. It is potentially the case that in the absence of a clearly defined construct of shame, shame may mean different things to different authors.

As suggested by Lewis (1971) the emphasis on the self that is elicited by shame can lead to intra-psychic pain because the individual's core self is at stake (Lewis, 1971). It is therefore unsurprising that research has consistently demonstrated that shame is linked with social anxiety, generalised anxiety, depression, eating disorders, low self-esteem, psychological distress and hostility (Fergus, Valentiner, McGrath & Jencius, 2010; Goss & Allan, 2009; Kim, Thibodeau, Jorgensen & Randall, 2011; Velotti, Garofalo, Bottazzi & Caretti, 2016). Shame is also an important construct in understanding violent behaviour. Research has demonstrated that a proclivity for shame is linked to anger, which is related to

violent offending (Andrews et al., 2000; Bennett, Sullivan & Lewis, 2005; Harper & Arias, 2004; Paulhus, Robins, Trzesniewski & Tracy, 2004; Tangney & Dearing, 2002; Tangney et al., 2011; Howells, 2011). Based on his clinical experiences working with male prisoners, Gilligan (1997) suggested that shame is linked with violent acts and that some violent men hide a deep sense of shame behind a mask of bravado and arrogance. When feelings of shame, humiliation, ridicule and disrespect are evoked, violence acts as a mechanism to replace feelings of shame with pride and self-esteem (Gilligan, 1997). It is therefore unsurprising that in forensic populations, shame has been linked with anger, hostility and violent offending (Andrews, Brewin, Rose & Kirk, 2000; Bennett, Sullivan & Lewis, 2005; Harper & Arias 2004; Howells, 2004; Paulhus, Robins, Trzesniewski & Tracy, 2004; Tangney & Dearing 2002; Tangney, Stuewig & Hafez, 2011). Although shame has previously been linked with violence in forensic populations, few authors have attempted to consider and clarify constructs of shame and anger, or unravel the mechanisms that relate them both (see Heidenberg & Andrews, 2011; Velotti, Elison & Carlo, 2014;). The current study will therefore include a focus on theories that unpick the relationship between shame and anger as well as theories concerned with shame.

The evolutionary perspective of shame and anger is based on social rank theory (Gilbert, 1997), suggesting that both emotions are centred on maintaining social status and rank. Shame acts as a signal when social status is threatened which leads to either an acceptance of lowered status through submission and avoidance of further conflict, behaviours that increase social attractiveness, or strategies that are aimed at signalling power such as anger and aggression (Gilbert, 1997). The strategy

adopted will depend on prior learning experiences, situational factors and physiological states (Gilbert & Miles 2014). Therefore, dominance and threat-related behaviours such as anger and aggression can be used to cope with shame and the subsequent threat to social rank.

In line with the evolutionary perspective, Lewis' (1971) shame rage theory also suggests that anger is a defensive response against shame. She suggests that feelings of shame, powerlessness and defectiveness initiate a hostile anger or humiliated fury. Therefore, anger protects the self by shifting the blame to the other, relieving the individual from the unbearable feeling of shame. Both theories suggest that anger is based on shame related to threats to ego or social rank; however, in shame-rage theory anger is motivated by challenges to self-concept whereas the evolutionary perspective is more concerned with status and social rank.

State anger occurs in response to a situation and can vary in intensity and frequency whereas trait anger refers to stable personality characteristics relating to anger proneness (Deffenbacher et al., 1996). Studies have demonstrated stronger correlations between shame and trait anger than shame and angry temperament (Farmer & Andrews, 2009; Hejdenberg & Andrews, 2011; Hoglund & Nicholas, 1995; Tangney, Wagner, Fletcher & Gramzow, 1992). However, this finding is inconsistent across the literature: although Farmer and Andrews (2009) demonstrated that angry reaction was correlated with shame in a student sample, the same correlations were not found in a young offender population. Neither state nor trait anger correlated with shame in this population. Harper, Austin, Cerccone and Arias (2005) found no significant difference between shame and trait anger or shame and

state anger in male students and this finding was mirrored in a population of female offenders (Milligan & Andrews, 2005). Hejdenberg and Andrews (2011) found that different aspects of shame (e.g. behavioural shame) demonstrated different relationships to anger and suggested that there is a need to differentiate types of shame to understand the associations between shame and anger.

One of the most prominent theories investigating shame and recidivism is Braithwaite's (1989) Reintegrative Shaming Theory. This theory suggests that shame that is carried out in a socially reintegrative way will decrease recidivism. If shaming is stigmatising it is likely to lead to shame displacement, anger and blame. However, findings investigating the relationship between shame and recidivism in offenders have also been contradictory. Single item shame and guilt ratings were completed within the first four weeks of the prison term of 1,243 male young offenders who had committed a variety of offences (e.g., acts of violence, fraud, vandalism and property, drug and driving offences). Results found that feelings of guilt at the beginning of a prison term led to lower rates of recidivism whereas feelings of shame correlated with higher rates (Hosser, Windzio & Greve, 2008). In a recent study, it was found that the presence of shame did not directly predict recidivism in 476 male and female jail inmates (Tangney, Stuewig & Martinez, 2014). Demographic information about criminal history was not reported. The authors suggested two pathways explaining how shame might be linked to recidivism. Shame positively predicted recidivism through externalisation of blame; however, without externalisation of blame, shame inhibited recidivism.

The constructionist approach suggests that the prevailing view in forensic



psychology assumes that shame is a negative emotion that leads to avoidance (Leach & Cidam, 2015). This approach suggests that there is a bias in the literature due to this negative focus, and states that shame can be helpful under the right circumstances, leading to co-operation, prosocial behaviour and self-improvement. Retzinger and Scheff (1996) state that shame may have different meanings across cultures and that Western cultures view shame in a more constricted and negative way than in Eastern societies. Therefore, findings in any given study will depend on the measurement of shame used and the author's conceptualisation of shame.

One possible cause of the discrepancies in the extent to which different studies in the forensic literature link shame and anger, and shame and recidivism, could be the large variations in the conceptualisation and measurement of shame. We must first understand the conceptualisation of shame to understand its relationship with other constructs. It is therefore vital to determine exactly what each author is measuring when they refer to shame because the same word could be being used to describe entirely different concepts. The current review will discuss different shame conceptualisations and measures in the forensic literature.

As with anger (Hejdenberg & Andrews, 2011), shame has also been conceptualised and measured by focusing on either trait or state aspects (Goss, Gilbert & Allan, 1994). State shame refers to shame felt in the moment in response to a particular situation and is measured using scales that assess an individual's response to a range of scenarios. Measures that have focused on state shame include the Test of Self Conscious Affect (TOSCA; Tangney, Wagner & Gramzow, 1989) and the Offence Related Shame and Guilt scale (ORSGS; Wright & Gudjonsson,

2007). In contrast, trait shame involves a more pervasive and enduring stable sense of shame resulting in feelings of incompetence and inferiority. Measures that utilise trait shame focus on the frequency with which individuals experience particular thoughts or feelings (e.g. feeling inadequate and full of self-doubt). Measures of shame that focus on trait shame include the Internalised Shame Scale (ISS; Cook, 1993) and the Other as Shamer scale (OAS; Goss, Gilbert & Allan, 1994).

The current review was constructed in two parts (see Tilghman-Osborne, Cole & Felton, 2010 for an example). The first part aimed to systematically investigate how researchers have attempted to conceptualise shame in forensic populations. The second part aimed to provide an initial evaluation of the measures of shame used within these papers. This review intended to provide researchers with a comprehensive examination of the literature, which could be used to accurately identify and select appropriate conceptualisations and measures of shame, relevant to intended research questions.

## **Methods**

### **Search strategy**

The following electronic bibliographic databases were examined using a comprehensive search strategy. This search aimed to identify all studies that measured shame in forensic populations. The interface of OVID was used to search Medline, Embase, and Psycinfo: Ovid medline(R) (1950 to December 2016); Ovid embase (1980 to December 2016); Ovid Psycinfo (1806 to December 2016). Shame

as a concept was searched for by using the search term 'Shame' in isolation. Then measurements were searched using: 'measur\*', 'questionnaire\*', 'self-report', 'self-assessment\*', 'outcome assessment\*', 'scale\*', 'inventor\*', 'psychometric\*', 'survey\*', 'rating\*' and 'test\*'. Finally, forensic populations were captured using: 'prison\*', 'offen\*', 'perpetrator\*', 'crim\*', 'delinq\*', 'convict\*', 'felon\*', 'foren\*'. Following the three individual searches all three searches were combined using the OVID interface. The National Offender Management and the Howard League for Penal Reform websites were hand searched; however, no relevant literature was found.

A four-stage search process was utilised (see Figure 1). Titles, then abstracts and full texts were screened in line with the inclusion criteria. The bibliographies of the final texts were then hand searched for additional relevant articles, however, no new papers were added. Duplicates were electronically or manually removed. The 22 full papers that fitted the criteria were organised using an Excel spreadsheet. Finally, the measures used across the 22 papers were individually evaluated.

### **Inclusion and Exclusion Criteria**

The search focused on published empirical studies. Inclusion criteria included: published studies, adults over 18 years old, studies conducted in forensic populations (as previously described), the utilisation of an instrument using more than one question to explicitly measure shame and for the article to be published in English. Studies were excluded when: authors did not explicitly discuss and attempt to measure shame, a juvenile only sample was used, the study was not conducted in a forensic population, the article was a review or theoretical article and the article was

un-published grey literature including dissertations.

### **Type of participants**

Studies were considered if they included participants over the age of 18 and were within a forensic population as previously described; this included individuals with a current or previous conviction who were based in prison or in a community service.

### **Types of outcome measure**

This systematic review considered all empirical primary studies (i.e. not review or theoretical studies) within forensic populations where the author explicitly discussed and attempted to measure shame. To improve comprehension and accuracy of the data included in the current review, additional information regarding measures and their psychometric properties was sought from other sources. This included attaining publications relating to the properties and direct correspondence with authors.

To guide the selection of measures the following appropriate criteria proposed by Tilghman-Osborne, Cole and Felton (2010) were used, which included:

- 1) When there were multiple versions of a measure, articles that focused on the most recent version were used. This ensured that the conceptualisation and measure of shame used were informed by the author's most recent research.
- 2) Only articles that contained measures with more than one question were included. Measures assessing shame using only one question were excluded because the

author(s) were not explicitly conceptualising shame (e.g., “how much shame do you feel?”); they were asking participants to conceptualise shame and this could differ depending on the participants’ understanding of this concept.

- 3) The search was limited to articles written in English.
- 4) Only published articles and chapters were used in the initial search; dissertations were not considered. Grey literature was excluded to investigate current controversies in the literature and provide the reader with clear definitions and measures of shame that were easily accessible. This was done to aid researchers’ decision making about conceptualisations and appropriate measurement of shame.

### **Quality evaluations**

The current review aimed to systematically evaluate constructs and measures of shame in forensic populations and therefore the focus of the review was on the quality of measures rather than the quality of the studies included. The measures were critically evaluated using quality criteria and rating systems outlined by either Terwee et al. (2007) or Sklar, Groessl, O’Connell, Davidson and Aarons (2013).

Across these two review studies, eight quality criteria were applicable to the current review and therefore they were used to form the quality framework. These criteria included conceptual clarity, content validity, internal consistency, construct validity, convergent validity, test-retest reliability and interpretability (see Appendix B).

Conceptual clarity was demonstrated if a clear description of shame was provided, including evidence or a theoretical model. Content validity was demonstrated if a clear description of the measurement concept and item selection was stated. Internal

consistency was examined to assess the measures ability to assess shame as a single construct using a moderate to high Cronbach's alpha ( $>.70$ ). Convergent validity was illustrated if the measure was correlated highly ( $>0.7$ ) with another measure of shame. Test re-test reliability was demonstrated if a weighted Kappa of  $>.70$  was presented. Interpretability was proven if means and standard deviations were presented for two populations, including at least one forensic population. Construct validity was demonstrated if results corresponded with at least 75% of the expected hypothesis'. All criteria were scored as 0 for absent and 1 for present. A partial rating of 0.5 was given to convergent validity or internal consistency if findings were contradictory (e.g., only one out of two studies demonstrated internal consistency or, one out of two measures correlated above the accepted level of  $>0.7$ ).

## **Results**

Using the above identified search terms, 581 bibliographies were found. This number reduced to 438 after de-duplication. Out of the 438 bibliographies, 138 were excluded based on unrelated titles, however, when titles were ambiguous bibliographies were not excluded. Two hundred and eighty eight full abstracts were searched and of these 216 were excluded because they did not mention a measure of shame in a forensic population. Eighty-two full texts were searched and 60 were excluded based on the above criteria. Twenty-two articles met the full inclusion criteria (see Figure 1). [Table 1](#) lists these studies and includes the following information: title, year of publication, author(s), definition of shame, measurement of shame, demographics of the study population (including age, gender), number of participants and main findings.

Across the 22 articles the earliest was published in 1994 and the majority (74%) were published between 2006 and 2015. The majority investigated the relationship between shame and risk behaviours/factors including: anger (36%), substance misuse (14%), recidivism (14%) and reintegrate versus stigmatising shaming (9%). Other topics included intervention studies (18%) and the development of new shame measures (18%).

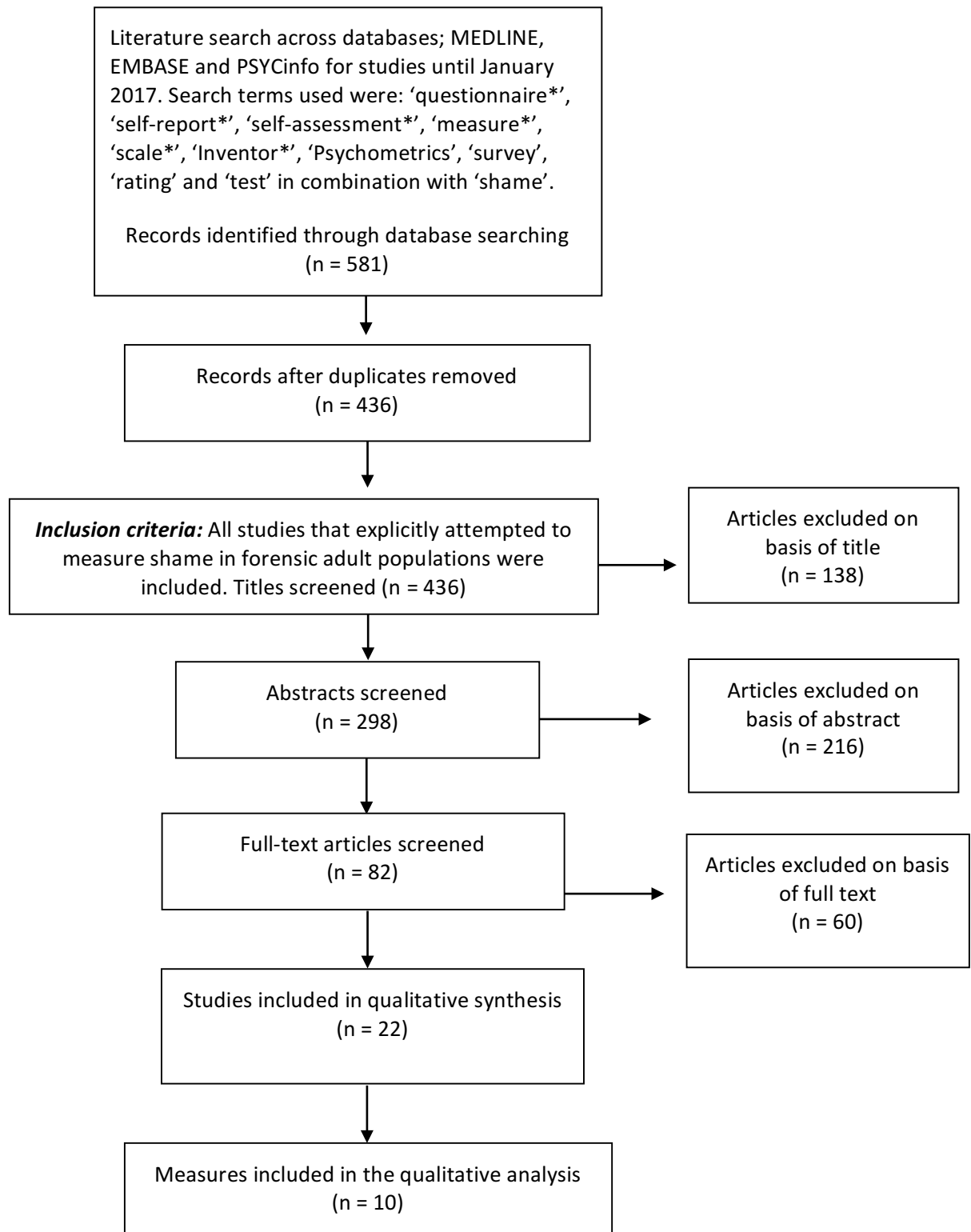


Figure 1: Flow chart illustrating papers reviewed throughout the systematic review search process



Author	Title	Clear definition of	Lewis 1971	Evolutionary theory	Self/behaviour distinction	Linked to avoidance, hiding or escape	Measure of shame	Study population	N	Gender	Age	Main findings
Brazao, da Motta, Rijo, Salvador, Pinto-Gouveia & Ramos (2015)	Clinical change in anger, shame, and paranoia after a structured cognitive-behavioural group program: Early findings from a randomised trial with male prison inmates	No	N/A	N/A	N/A	N/A	Other as Shamer Scale (OAS)	Three Portuguese prisons	24 treatment group, 24 control group	Male	19 - 40 years	No differences between groups were found in anger-state and external shame.
Dearing, Stuewig & Tangney (2005)	On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use	Yes	Yes	No	Yes	Yes	TOSCA-SD	Prison inmates	332	90% male	Average = 31.4 years	Shame-proneness was positively associated with alcohol and drug use.
Farmer & Andrews (2009)	Shameless yet angry: shame and its relationship to anger in male young offenders and undergraduate controls	Yes	No	No	No	Yes	Experience of Shame Scale (ESS)	Young offender institute mainly containing those on remand	56	Male	18-21 years	The young offenders displayed significantly higher levels of anger and depression, but significantly lower levels of shame than undergraduates. Significant relationship between shame and anger were found only in controls.

Author	Title	Clear definition of shame	Lewis 1971	Evolutionary theory	Self/behaviour distinction	Linked to avoidance, hiding or escape	Measure of shame	Study population	N	Gender	Age	Main findings
Harris (2003)	Reassessing the dimensionality of the moral emotions	No	N/A	N/A	N/A	N/A	Shame-related emotions	Drink driving offenders	720	76% male	Mean 30	Expected distinctions between shame and guilt were not found. Identified three factors: shame-guilt, embarrassment-exposure and unresolved shame.
Harris (2006)	Reintegrative shaming, shame, and criminal justice	No	N/A	N/A	N/A	N/A	Shame related emotions	Drink driving offenders	720	76% male	Mean 30	Shame-related emotions were predicted by social disapproval.
Jackson & Bonacker (2006)	The effect of victim impact training programs on the development of guilt, shame and empathy among offenders	No	N/A	N/A	N/A	N/A	TOSCA-SD	Probationers on a supervision order	43	74% male	Range 18-50	No significant differences between offenders undertaking a victim impact training programme and control's on levels of shame, guilt and empathy.
Jackson (2009)	The Impact of Restorative Justice on the Development of Guilt, Shame, and Empathy among participants in a victim impact training program	No	N/A	N/A	N/A	N/A	TOSCA-SD	Probationers	43	74% male	Range 18-50	No significant differences between offenders undertaking a victim impact training programme and controls on levels of shame, guilt and empathy. However, a significant relationship was found among gender, programme type, guilt, shame and empathy.

Author	Title	Clear definition of shame	Lewis 1971	Evolutionary theory	Self/behaviour distinction	Linked to avoidance, hiding or escape	Measure of shame	Study population	N	Gender	Age	Main findings
Laithwaite et al., (2009)	Recovery After Psychosis (RAP): A compassion focused programme for individuals residing in high security settings	No	N/A	N/A	N/A	N/A	Other as Shamer Scale	Forensic psychiatric inpatients	18	Male	Mean 36.9	Small magnitude of change for shame pre/post intervention (compassion focused therapy)
Lowinger & Solomon (2004)	PTSD, Guilt, and shame among reckless drivers	No	N/A	N/A	N/A	N/A	TOSCA	Men on probation convicted of causing death through reckless driving.	38 plus 37 matched controls	Male	Range 19-30	Drivers that have accidentally caused death through reckless driving are a high-risk group for PTSD and accident related guilt. PTSD and guilt are associated with severity of punishment and degree of responsibility.
Milligan & Andrews (2005)	Suicidal and other self-harming behaviour in offender women: The role of shame, anger and childhood abuse	No	N/A	N/A	N/A	N/A	Experience of Shame Scale	Prison inmates in the Midlands, UK	89	Female	Mean 31.8	There is a relationship between shame and self-harm.
Morrison & Gilbert (2001)	Social rank, shame and anger in primary and secondary psychopaths	Yes	No	Yes	No	Yes	The Internalised Shame Scale	Forensic psychiatric inpatients	50	Male	Mean 36.3	Differences in primary and secondary psychopaths in shame.
Murphy & Harris (2007)	Shaming, shame and recidivism	No	N/A	N/A	N/A	N/A	Shame Emotions	Tax offenders	652	83% male	Range 25-76 Mean 50.43	In line with Braithwaite those who felt their experience was reintegrative were less likely to report recidivism.

Author	Title	Clear definition of shame	Lewis 1971	Evolutionary theory	Self/behaviour distinction	Linked to avoidance, hiding or escape	Measure of shame	Study population	N	Gender	Age	Main findings
Murphy & Helmer (2013)	Testing the importance of forgiveness for reducing repeat offending	No	N/A	N/A	N/A	N/A	Shame Emotions	Tax offenders	1250	84% male	Range 29-81 Mean 55.8	Stigmatising shaming had no direct impact on compliance related behaviours, it displaced taxpayers sense of responsibility. Forgiveness, was linked with increased co-operation.
Rosenman, Ritchie & Laux (2009)	A restorative justice approach to empathy development in sex offender: an exploratory study	No	N/A	N/A	N/A	N/A	The Personal Feelings Question – 2 (PFQ-2)	Sex Offenders on patrol living in the community	13	Male	40 average	Failed to support link between levels of exposure to a sexual abuse survivor and levels of developed empathy. No significant changes in levels of shame and guilt.
Shanahan, Jones & Thomas-Peter (2011)	Are you looking at Me, or Am I? Anger, Aggression, shame and self-worth in violent individuals	Yes	No	No	No	No	The Internalized Shame Scale	One group of forensic psychiatric inpatients and one group of violent prisoners	22 participants in each group	Male	Range 21-25 Average 38.9	No significant difference between groups was found in irrational beliefs, self-esteem, internalised shame, and the experience/expression of anger. Unhealthy anger may serve to protect against shame and low self-worth.

Author	Title	Clear definition of shame	Lewis 1971	Evolutionary theory	Self/behaviour distinction	Linked to avoidance, hiding or escape	Measure of shame	Study population	N	Gender	Age	Main findings
Stuewig, Tangney, Mashek, Forkner, & Dearing (2009)	The Moral Emotions, Alcohol Dependence, and HIV risk behaviour in an incarcerated sample	Yes	Yes	No	Yes	Yes	TOSCA-SD	Prison inmates	368	Male	Mean 31.2	In those low on alcohol dependence, shame proneness was negatively related to risky sexual behaviour.
Stuewig, Tangney, Heigel, Harty & McCloskey (2010).	Shaming, blaming, and maiming: Functional links among moral emotions, externalization of blame and aggression	Yes	Yes	No	Yes	Yes	TOSCA-SD	Prison inmates	507	70% male	average 32	No direct relationship between shame and aggression. There was an indirect relationship between shame and aggression through externalisation of blame.
Tangney, Stuewig, Mashek & Hastings (2011)	Assessing jail inmates proneness to shame and guilt	Yes	Yes	Yes	No	Yes	TOSCA-SD	Prison inmates	550	379 male 171 female	Range 18-69 average 32	No evidence was found suggesting shame serves as an inhibitory mechanism for recidivism.
Tangney, Stuewig & Martinez (2014)	Two faces of shame: the roles of shame and guilt in predicting recidivism	Yes	Yes	Yes	No	Yes	TOSCA-SD	Prison inmates	476	67% male	Range 18-70 Mean 33	Shame proneness predicted recidivism via externalisation of blame.
Ward, Hudson & Marshall (1994)	The abstinence violation effect in child molesters	No	N/A	N/A	N/A	N/A	The Differential Emotions Scale	Prison inmates	26	Male	Mean 42.9	Higher levels of shame after abstinence violation effect.

Author	Title	Clear definition of shame	Lewis 1971	Evolutionary theory	Self/behaviour distinction	Linked to avoidance, hiding or escape	Measure of shame	Study population	N	Gender	Age	Main findings
Wright & Gudjonsson (2007)	The development of a scale for measuring offence-related feelings of shame and guilt	Yes	Yes	Yes	No	Yes	The Offence Related Shame and Guilt scale (ORSGS)	Forensic psychiatric inpatient	60	Male	Not stated	Shame and guilt are distinct emotions.
Wright, Gudjonsson & Young (2008)	An investigation of the relationship between anger and offence-related shame and guilt	No	N/A	N/A	N/A	N/A	The Offence Related Shame and Guilt scale (ORSGS)	Forensic psychiatric inpatients.	Mean 60	Male	Not stated	Offence related shame is associated with elevated levels of anger difficulties.

*Table 1: A summary of information gained from the 22 bibliographies.*

## **Defining Shame**

A clear coherent single definition of shame was provided in nine out of the 22 (41%) reviewed studies. In five out of the 22 studies reviewed (Dearing, Stuewig & Tangney, 2005; Stuewig et al., 2009; Stuewig et al., 2010; Tangney et al., 2014; Tangney et al., 2011) shame was defined as a negative evaluation of the entire self, using Lewis' (1971) conceptualisation of shame. Shame was differentiated from guilt using the self/behaviour distinction and discussed in regards to increased motivation to hide or disappear rather than engage in reparative behaviours. As demonstrated by the following quote from Stuewig et al., (2010) all studies emphasised the cost or negative aspects of shame.

Both shame and guilt are negative or uncomfortable emotions. Shame, however, involves a negative evaluation of the entire self vis-à-vis social and moral standards. Guilt focuses on specific behaviours (not the self) that are inconsistent with such standards. ... Guilt is apt to motivate reparations. Shame is apt to motivate efforts to hide or disappear. (Stuewig et al., 2010, p.91)

In three out of the 22 studies shame was described using Gilbert's evolutionary perspective of shame. As demonstrated by the following quote from Wright and Gudjonsson (2007) all three studies focused on a negative self-evaluation coupled with a desire for avoidance and concealment.

Shame is constructed by Lewis (1971) as involving self-other comparisons that led to a negative evaluation of the self. This leads to sense of worthlessness, powerlessness and inferiority... Thus shame involves a sense of scrutiny of the self by a real or imagined audience, leading to a sense of exposure and desire to

escape or hide.... According to Gilbert, shame alerts the self to detrimental changes in social status ... shame is associated with the submissive defensive strategy (Gilbert & McGuire, 1998) and thus is associated with a sense of inferiority, and concealment, avoidance, and inhibition (Wright & Gudjinsson, 2007, p308)

In out of the 22 studies shame was defined as a condemnation of the global self combined with other condemnation. This was the only definition that did not discuss the action tendency of hiding or avoidance in combination with this feeling, “A very painful condemnation of the global self, coupled with an awareness of how the self would appear to others” (Shanahan, Jones & Thomas-Peter, 2011, p.78).

In 13 of the 22 reviewed studies a measure of shame was used but no clear definition of shame was provided, or a definition of shame was provided but it was not differentiated from the other moral emotions (guilt or embarrassment). In 4 of these 13 studies (Brazao et al., 2015, Laithwaite et al., 2009, Milligan & Andrews, 2005, Ward, Hudson & Marshall, 1994) shame was not defined using any theory or model. In one of these studies (Harris, 2003) shame was discussed using various definitions that focused on negative self-evaluations and negative evaluations of the self by others. However, after defining shame in the introduction the authors attempted to create a measure of shame but their findings suggested that shame was not a unified concept. The authors therefore presented three factors, which represented the moral emotions of shame-guilt, embarrassment-exposure and unresolved shame.

In three of the 13 studies that did not provide a clear unified definition of shame, Braithwaite’s (1989) reintegrative shaming theory was used to discuss shame. In all three



of these studies, the authors discuss multiple definitions of shame but suggest that moral emotions (shame, guilt, embarrassment etc.) are not separate constructs. In Harris (2006), the author suggests three factors that represent moral emotions: shame-guilt, embarrassment-exposure and unresolved shame. In Murphy and Harris (2007) and Murphy and Helmer (2013) the authors discuss shame acknowledgement (including items related to guilt) and displacement (including items related to anger).

In five of the 13 studies that did not provide a clear unified definition of shame (Jackson, 2009, Jackson & Bonacker, 2006, Lowinger and Solomon, 2004, Roseman, Ritchie & Laux, 2009, Wright, Gudjonsson & Young, 2008) shame was discussed in a variety of ways using multiple perspectives and theories, however, the authors did not state or agree on a unified concept of shame. In one of these studies (Roseman, Ritchie and Laux, 2009) the authors explicitly state that there is a lack of discussion around shame and highlight the need for further exploration of the construct.

### **Measuring shame**

The 22 articles reviewed here contained 10 distinct measures of shame. These 10 measures were then evaluated using information gathered from articles based on the original measure, the 22 articles reviewed and relevant grey literature. Table 2 shows descriptions of the psychometric properties of these measurements. Five of the measures focused on state shame, four focused on trait shame and one used a combination of trait and state shame.

Author	Measure	Conceptual clarity	Content Validity	Internal consistency Forensic	Test re-test reliability Forensic	Convergent validity	Interpretability	Interpretability Forensic	Construct validity	Total score
Cook (1987, 1994, 2001)	The Internalised Shame Scale (ISS)	Present	Present	Present	Absent	Present	Present	Present	Present	7/8
Goss, Gilbert & Allan (1994), Allan, Gilbert & Goss (1994)	Other as Shamer Scale (OAS)	Present	Present	Present	Absent	Partial	Present	Present	Present	6.5/8
Izard 1971, 1993	Differential Emotions Scale (DES-IV)	Present	Present	Present	Absent	Absent	Present	Present	Present	6/8
Tangney, Wagner & Gramzow, (1989)	Test of Self Conscious Affect (TOSCA)	Present	Present	Present	Absent	Absent	Present	Present	Present	6/8
Hanson & Tangney (1996)	Test of Self Conscious Affect Socially Deviant (TOSCA-SD)	Present	Present	Partial	Absent	Absent	Present	Present	Present	5.5/8
Wright & Gudjonsson (2007)	The Offence Related Shame and Guilt Scale (ORSGS)	Present	Present	Present	Absent	Absent	Present	Present	Present	5/8

Harder & Zalmen (1990)	Personal Feelings Questionnaire-2 (PFQ-2)	<b>Present</b>	<b>Present</b>	<b>Absent</b>	<b>Absent</b>	<b>Absent</b>	<b>Present</b>	<b>Present</b>	<b>Absent</b>	<b>4/8</b>
Murphy and Harris, 2007; Murphy, 2013	Shame Emotions	<b>Present</b>	<b>Present</b>	<b>Partial</b>	<b>Absent</b>	<b>Absent</b>	<b>Absent</b>	<b>Present</b>	<b>Absent</b>	<b>3.5/8</b>
Harris (2003, 2006)	Shame-related Emotions	<b>Present</b>	<b>Present</b>	<b>Partial</b>	<b>Absent</b>	<b>Absent</b>	<b>Absent</b>	<b>Absent</b>	<b>Present</b>	<b>3.5/8</b>
Andrews, Qian & Valentine (2002)	Experience of Shame Scale (ESS)	<b>Absent</b>	<b>Absent</b>	<b>Present</b>	<b>Absent</b>	<b>Absent</b>	<b>Present</b>	<b>Present</b>	<b>Absent</b>	<b>3/8</b>

*Table 2: Descriptions of the psychometric properties of measures of shame used in forensic populations*

## State measures of shame

**Test of Self Conscious Affect (TOSCA; Tangney, Wagner & Gramzow, 1989).** The TOSCA was created using adult and college students' descriptions of personal experiences of shame, pride and guilt. It is a scenario based test measuring shame, guilt, externalisation, dissociation and pride. The measure suggests that shame is a negative, internal, global, uncontrollable and stable evaluation of the self, leading to feelings of smallness and worthlessness and the tendency to hide and disappear (Lewis, 1971). Tangney et al., (1989) used these conceptualisations of shame to create scenarios in the TOSCA, demonstrating conceptual clarity and content validity. Shame is characterised by responses that involve negative self-evaluations (e.g. "I am terrible") and by withdrawal behaviour (e.g. hiding).

Internal consistency (Cronbach alpha coefficients = 0.70) was demonstrated in 38 men convicted of causing death by reckless driving (Lowinger & Solomon, 2010). Construct validity was also demonstrated through expected significant positive correlations between shame and blaming self ( $r = 0.29$ ) and the belief that the accident could have been prevented ( $r = 0.29$ ). Interpretability was demonstrated through reported means and standard deviations of the TOSCA scale in both reckless drivers ( $M = 2.27$ ,  $SD = 0.77$ ) and in a control group (Lowinger & Solomon, 2010;  $M = 1.19$ ,  $SD = 0.54$ ). Test re-test reliability and convergent validity were not reported in a forensic population.

**Test of Self Conscious Affect Socially Deviant (TOSCA-SD; Hanson & Tangney, 1996).** The TOSCA-SD is an adapted version of the TOSCA that utilises a scenario based measure to assess shame and guilt proneness. The TOSCA-SD uses 13 scenarios which are designed to be relevant to incarcerated or other "socially deviant" populations. Interpretability was demonstrated by Jackson and Bonacker (2006), who reported means and standard deviations of 43 adult probationers (Negative appraisal  $M = 13.63$ - $14.45$ ,  $SD = 4.06$ - $4.16$ , Behavioural Avoidance  $M = 11.00$ - $11.45$ ,  $SD = 2.78$ - $3.11$ ) and

23 controls (Negative appraisal M= 15.15-14.90, SD=3.70-3.11, Behavioural Avoidance M=10.30-10.80, SD=3.64-2.14). Convergent validity was not reported in a forensic population. In regards to test-retest reliability Tangney et al., (2011) cited Cripps (1997) and Hanson (1996). However, Cripps (1997) only reported validity and reliability for the guilt scale and test re-retest reliability was not reported in Hanson (1996).

Internal consistency was not demonstrated in the TOSCA-SD shame scale in a study of 35 prison inmates ( $\alpha = 0.47$ ) and the authors concluded that the low alpha level was due to idiosyncratic responses in the avoidance items (Hanson, 1996). The TOSCA-SD shame scale was therefore divided into two shame subscales consisting of negative appraisal items (e.g. items based on negative global evaluations of the self) and behavioural avoidance items (e.g. feelings of exposure, hiding and escaping). In three subsequent studies using the TOSCA-SD (Dearing, Stuewig & Tangney, 2005; Stuewig, Tangney, Mashek, Forkner & Dearing, 2009; Stuewig et al., 2010) the authors cite Hanson's (1996) findings and suggest that the most valid way to measure shame in offenders is through the negative self-appraisal shame subscale. However, even when the negative self-appraisal subscale was used in isolation, the studies still did not report internal consistency above the accepted alpha level of 0.70 (0.63, 0.59 and 0.59 were reported retrospectively). Further, in a population of 42 offenders a Cronbach's alpha of 0.67 was reported for the negative self-appraisal subscale and 0.38 for behavioural avoidance subscale (Jackson, 2009). In Tangney et al., (2011) the authors suggest that behavioural avoidance items may capture a different phenomenon in an offender population in comparison to the general population. They suggest the behavioural avoidance subscale may represent a desire to hide offences and punishment rather than a desire to hide feelings of shame.

In a later study, Tangney et al., (2011) examined both shame subscales in 550 jail inmates and stated that due to the reasonable correlations ( $r=.35$ ) both subscales should be

used to measure shame. Construct validity was reported through expected significant positive correlations with personal distress ( $r=.43$ ), externalisation of blame ( $r=.47$ ), anxiety ( $r=.42$ ), traumatic stress ( $r=.24$ ), depression ( $r=.40$ ), violence potential ( $r=.21$ ), anti-social personality disorder ( $r=.19$ ), and egocentricity ( $r=.19$ ). The shame scale was also, as expected, negatively correlated with self-control ( $r= -.20$ ) and self-esteem ( $r=.43$ ). Based on these findings Tangney et al., (2011) concluded that shame should be measured using both shame subscales in line with community findings.

Internal consistency for the TOSCA-SD shame scale was demonstrated in a later study by Tangney et al., (2014) who found an acceptable Chronbach's alpha level ( $\alpha = 0.71$ ). Findings in this study revealed that shame was not directly linked to recidivism; however, when externalisation of blame was considered, shame exerted a positive mediated effect on recidivism. The authors then examined the separate shame subscales, and results indicated that the relationship between shame and recidivism, mediated by externalisation of blame, was driven mainly by the Behavioural Avoidance subscale. When tested in isolation the Negative Self appraisal subscale was not directly related to recidivism or indirectly related via externalisation of blame. However, the Behavioural Avoidance subscale had a significant direct and indirect effect on recidivism. The authors concluded that shame may have two pathways: one that is destructive and another with a constructive potential.

**The Offence Related Shame and Guilt Scale (ORSGS; Wright & Gudjonsson, 2007).** This scale was designed to measure state levels of shame and guilt in response to an index offence. Wright and Gudjonsson (2007) used conceptualisations of shame that emphasised self-other comparisons leading to a negative evaluation of the self (Lewis, 1971). This was associated with inferiority and thus concealment, avoidance and inhibition (Gilbert & McGuire, 1998). Wright and Gudjonsson (2007) then explicitly used these conceptualisations of shame to create items in the ORSGS focusing on avoidance

and negative self-evaluation. Shame was therefore adequately conceptualised and these conceptualisations were explicitly used to create the ORSGS demonstrating conceptual clarity and content validity.

The ORSGS is a 10-item scale consisting of a 6-item subscale measuring guilt and 4-item subscale measuring shame. In a sample of 60 forensic psychiatric inpatients, Wright, Gudjonsson and Young (2008) reported reasonable internal consistency (Chronbach's alpha ( $\alpha = 0.78$ ) and construct validity (significant positive correlations with state anger at 0.37). Interpretability was also demonstrated in two forensic populations, including 60 forensic psychiatric inpatients ( $M = 13.6$ ,  $SD = 7.4$ ; Wright, Gudjonsson & Young, 2008) and 58 male and female adolescents on probation in Canada ( $M = 24.17$ ,  $SD = 8.70$ , Spice, Viljoen, Douglas & Hart, 2015).

In a population of 65 forensic psychiatric inpatients (Wright & Gudjonsson, 2007) test-re-test reliability was reported ( $r = .60$ ), however, the correlation was below the accepted minimum correlation of  $r = 0.70$  suggested by Terwee et al. (2007). Convergent validity was not demonstrated because significant positive correlations with the TOSCA-3 shame were below the level of 0.7 ( $r = 0.39$ ) recommended by Terwee et al., (2007). However, a stronger significant positive correlation was demonstrated between ORSGS shame and TOSCA-3 guilt ( $r = .42$ ) suggesting that ORSGS shame and TOSCA-3 guilt are more closely related concepts. This raises questions about how shame and guilt are measured across both the TOSCA-3 and the ORSGS.

**Shame-related emotions (Harris, 2003, 2006).** Harris (2003) developed a self-report measure to investigate moral emotions including shame, guilt and embarrassment in 720 drink-driving offenders. Harris (2003, 2006) reported that shame-related emotions are not well understood in the literature and therefore he created a measure based on various conceptualisations of shame (e.g. Lewis, 1971; Tangney, 1999) demonstrating both conceptual clarity and content validity.

The questionnaire includes 23-items and asks participants to respond to these (e.g. during the conference/ court case I felt ashamed of myself) using a Likert scale ranging from 1 (not at all) to 5 (felt overwhelmed by it). The authors conducted a principle component analysis on these items and did not find expected distinctions between shame and guilt. From the 23-items, three factors emerged and scales were formed based on these. The first factor was shame-guilt because items that measured both shame and guilt loaded onto the same factor. The authors suggested that this finding was consistent with several theoretical perspectives that suggest shame and guilt are part of the same construct. The second factor was unresolved shame. Items that loaded on this factor measured unresolved negative feelings about the court case, such as feeling unfairly judged and an inability to decide if what they had done was wrong. Harris (2003) suggests that this factor is consistent with Lewis' (1971) conceptualisation of bypassed shame. The final factor consisted of items that investigated embarrassment, exposure and humiliation, and was called embarrassment-exposure. Shame-guilt was measured by 6 items (Cronbach's alpha, 0.86 in conference cases and 0.88 in court cases). Embarrassment-exposure was measured using 5 items (reliability alpha of 0.80 in conference cases and 0.88 in court cases) and unresolved shame was measured by 3 items (Cronbach's alpha of 0.55 in conference cases and 0.66 in court cases).

Interpretability could not be established because means and standard deviations were not reported. Construct validity was demonstrated for the unresolved shame construct through expected positive correlation with anger/hostility ( $r = .41$ ). The authors stated that this is consistent with findings suggesting that shame can result in aggression (Tangney, Wagner, Fletcher & Gramzow, 1992) particularly when unacknowledged (Lewis, 1971). Construct validity was also demonstrated in shame-guilt construct through an expected significant positive correlation with empathy ( $r = .58$ ). However, shame-guilt also had a negative relationship with anger/hostility ( $r = -.24$ ) and the authors reported that



this finding was consistent with the relationship demonstrated between TOSCA guilt and anger. This therefore suggests that shame-guilt may be a similar construct to TOSCA guilt.

**Shame emotions (Murphy and Harris, 2007; Murphy, 2013).** Murphy and Harris (2007) measured shame acknowledgment and shame displacement in 652 tax offenders using items drawn from Ahmed (2001) in line with Braithwaite's (1989) reintegrative shaming theory. This theory suggests that shame encompasses all forms of social disapproval. Reintegrative shaming occurs when shaming is carried out in a way that is respectful and healing and this reduces reoffending through shame acknowledgement (Braithwaite & Braithwaite, 2001). However, shaming that is carried out in a disrespectful and disapproving manner is stigmatising, leading to humiliation. This increases the likelihood of blame externalisation (or shame displacement) and increases feelings of hostility, defiance, non-compliance and anger, increasing offending (Ahmed, 2001; Braithwaite & Braithwaite, 2001).

Murphy and Harris (2007) and Murphy and Helmer (2013) used Braithwaite's (1989) theoretical conceptualisation of shame in their measure, and focused on shame acknowledgement and displacement, which demonstrated conceptual clarity and content validity. Construct validity was demonstrated by findings, suggesting that shame displacement led to higher non-compliance as expected by Braithwaite (1989). However, reintegrative shaming predicted less shame acknowledgement and shame acknowledgement did not predict non-compliance, which is not fully consistent with theoretical predictions by Ahmed (2001) and Braithwaite (1989). Therefore, construct validity was not demonstrated because less than 75% of the expected hypothesis's were demonstrated (Terwee et al., 2007). An adapted version of this measure was used by Murphy and Helmer (2013) to assess how tax offenders managed feelings of shame. Items taken from a study by Ahmed et al., (2001) were used to assess shame

acknowledgment and shame displacement. Internal consistency was demonstrated using Cronbach's alpha for the shame displacement scale ( $\alpha = 0.78$ ) but not for the shame acknowledgement scale ( $\alpha = 0.67$ ).

Construct validity was partially demonstrated by findings that were in line with theoretical predictions suggested by Braithwaite (1989). Participants who felt stigmatised were more likely to displace their shame and reported higher levels of reoffending. Whereas participants who felt the ATO was forgiving were less likely to displace shame and reported lower levels of reoffending. These results support Braithwaite (1989) and Ahmed's (2001) predictions that when people feel stigmatised they are more likely to displace their shame, feel anger and blame others. However, results also showed that forgiveness from loved ones predicted lower levels of shame acknowledgment. This contradicts Braithwaite's (1989) theory because this theory would suggest that reintergrative shaming (or forgiveness) should decrease offending via increased shame acknowledgement. Interpretability was partially demonstrated by both studies, indicating means and standard deviations, however both were investigating tax offenders (e.g. 652 tax offenders, Shame acknowledgment,  $M=2.45$ ,  $SD=0.96$ , Shame displacement,  $M=3.76$ ,  $SD=0.80$ , Murphy & Harris, 2007).

### **Trait approach measures**

**Personal Feelings Questionnaire-2 (PFQ-2, Harder & Zalma, 1990).** The original PFQ was used in clinical settings to assess affect tendencies and was later found to differentiate between shame and guilt (Harder & Lewis, 1987). Harder, Rockart and Cutler (1993) used theoretical conceptualisations suggesting that shame centres around a sense of vulnerability, awkwardness and inadequacy (Lewis, 1971). In their measure the authors focused on personality traits that were related to the construct of shame, demonstrating both conceptual clarity and content validity.

The shame sub scale of the PFQ-2 uses 10 shame based adjectives that focus on

the self (feeling humiliated, ridiculous, laughable, self-consciousness, stupid, childish, disgusting, helpless/paralysed, and feelings of blushing). Internal consistency, convergent validity, construct validity and test-re-test reliability were not demonstrated in forensic samples and only reported in student populations (Harder & Lewis, 1987; Harder, Rockart & Cutler, 1993). Interpretability was demonstrated in 13 males in sex offender treatment (Roseman, Ritchie & Laux, 2009) means and standard deviations pre (M= 38.80-47.60, SD=5.29-14.93) and post treatment (M= 41.60-52.00, SD=5.77-13.45). Means and standard deviations were also reported for 71 college undergraduate students (M=16.72, SD=4.40).

**The Internalised Shame Scale (ISS: Cook, 1993, 1994, 1996).** The ISS is based on Kaufman's (1989) construct of internalised shame. He suggests that shame is the feeling of being painfully diminished in the eyes of others. When we are hurt by shame we internalise it believing that we are shameful, leading to an attempt to hide part of ourselves and thus resulting in alienation and isolation (Kaufman, 1989). Shame is therefore conceptualised in response to feeling diminished by ourselves and others. The ISS focuses on negative self and other opinions which directly relates to the construct of internalised shame above, demonstrating both conceptual clarity and content validity in the ISS.

The ISS is a 30-item scale based on the experiential descriptions of shame in both males and females undertaking alcohol recovery programs. Of the 30-items, 6 comprise a self-esteem subscale and the other 24 represent the internalised shame subscale focusing on self and others' opinions.

In a study of 44 adult male offenders convicted of a violent offence, Shanahan, Jones and Thomas-Peter (2010) found internal consistency for the ISS using Cronbach's alpha ( $\alpha = 0.89$ ). Convergent validity was demonstrated (Keen, 2008) in 106 male offenders by significant positive correlations between the ISS and DES-IV (.76) and ISS

and OAS (.83). Construct validity was established in a population of 50 male psychiatric inpatients formally classified with 'psychopathic disorder' from a high security mental health hospital (Morrison & Gilbert, 2001). Expected correlations between the ISS and low self-esteem (0.68), deviant history (0.67), avoidance (0.56), paranoid suspicion (0.55), social withdrawal (0.48) and resentment/ externalising blame (0.45) were demonstrated. Interpretability was shown in this sample ( $M=46.50$ ,  $SD=19.76$ ) and in a student sample (Del Rosario & White, 2006:  $M=27.48$ ,  $SD=15.76$ ).

**The Other as Shamer Scale (OAS; Goss, Gilbert and Allan, 1994).** The OAS is a measure of external shame (how others view the self), based on a subset of items from the ISS (Cook, 1994). The OAS conceptualises shame as a response to others negative evaluation of the self (real or perceived) using the evolutionary model of shame (Gilbert, 1992; Gilbert, Pehl, & Allan, 1994) and Lewis's (1971) definition of shame. In line with this conceptualisation of shame, the original statements used in the ISS have been rewritten moving the focus from self-evaluations (e.g. "at times I feel so exposed that I wish the earth would open up and swallow me") to evaluations about how others judge the self (e.g. "other people see me as small and insignificant"). Therefore, the OAS demonstrates both conceptual clarity and content validity.

In a population of 106 male offenders Keen (2008) demonstrated high internal consistency (Cronbach's  $\alpha = .95$ ). Convergent validity was demonstrated through significant positive correlations between OAS and ISS [ $r = 0.83$ ]. However, significant positive correlations between the OAS and DES-IV [ $r = 0.69$ ] did not meet the threshold suggested by Terwee et al. (2007) and therefore a partial rating was given. Construct validity was also established in this study through expected significant negative correlations with social rank ( $r = -.46$ ) in accordance with the evolutionary model of shame (Gilbert, 1992; Gilbert et al., 1994). Interpretability was reported in Goss, Gilbert and Allan (1994) in a population of 156 students ( $M=20.00$ ,  $SD=10.1$ ) and in Keen

(2008) in 106 male offenders ( $M=43.85$ ,  $SD=15.29$ ).

**Differential Emotions Scale (DES-IV; Izard, 1993).** The DES-IV is an adapted version of the Differential Emotion Scale (DES) designed for participants with limited education. The DES was created based on Izard's (1971) theory, suggesting that we innately have 10 fundamental emotions (interest, joy, surprise, sadness, anger, disgust, contempt, hostility, fear, shame, shyness and guilt) which are therefore universally discriminative in the human face. Izard (1971) photographed individuals demonstrating different emotion expressions and reported that shame was indicated by lowered gaze and head movements, drawn in lips that were tightened at the corners and protruding. This theory was used to create the measure demonstrating both conceptual clarity and content validity.

In a population of 106 male offenders (Keen, 2008) high internal consistency was reported for the DES-IV (Cronbach's  $\alpha = .90$ ). Test re-test reliability has not been reported in a forensic population but has been demonstrated in a large cross-cultural population of 2,407 people (Youngstrom & Green, 2003). Construct validity was established in a forensic population (Keen, 2008) through a significant negative correlation with social rank ( $r = -.44$ ) which would be expected based on the evolutionary model of shame (Gilbert, 1992; Gilbert et al., 1994). Interpretability was demonstrated in a non-clinical sample of 88 middle class mothers (Izard, Libero, Putnam & Haynes, 1993;  $M=5.77$ ,  $SD= 1.98$ ) and in a sample of 106 male offenders (Keen, 2008,  $M= 8.02$ ,  $SD=3.25$ ).

#### **A combination of both state and trait approaches**

**Experience of Shame Scale (ESS; Andrews, Qian & Valentine, 2002).** The Experience of Shame Scale (ESS: Andrews, Qian & Valentine, 2002) does not draw specifically on a theoretical conceptualisation of shame and therefore both conceptual

clarity and content validity cannot be established for the ESS. The ESS is a 25-item scale based on interviews with individuals in a depressed population. The questionnaire measures three aspects of shame: characterological shame (e.g. personal habits, manner with others, personal ability and the sort of person you are), behavioural shame (e.g. doing something wrong, saying something stupid and failure in competitive situations), and bodily aspects of shame (e.g. feeling ashamed of your body).

In a population of 40 males attending a domestic violence perpetrators support group Perez (2005) reported internal consistency using Cronbach's alpha (0.96). Farmer and Andrews (2009) explored shame and its relationship to anger in a sample of 56 male young offenders and 60 undergraduate students. No significant relationship was found between ESS shame and depression, anger or defensiveness as expected, and therefore construct validity for the ESS in forensic populations has not been demonstrated. Interpretability was demonstrated in this study through reported means and standard deviations in the student sample ( $M=49.67$ ,  $SD=12.82$ ) and the young offender sample ( $M=35.85$ ,  $SD=8.01$ ).

## **Discussion**

A systematic review was undertaken to investigate how researchers have conceptualised and measured shame in forensic populations. After identification of appropriate studies the psychometric properties of measures were evaluated. This review was undertaken to inform researchers when selecting shame measurements in forensic populations, relevant to their intended research question.

Initially, conceptualisations of shame that were used across studies were investigated. Through analysis of shame conceptualisations, it was found that only nine out of 22 studies reported a clear, single definition of shame. Four studies suggested that shame was not a unified concept and could not be distinguished from other moral emotions. Eight studies reported various shame conceptualisations and theories in their

introduction but did not agree on a single unified conceptualisation of shame. This suggests that most studies investigating shame in forensic populations failed to define shame as a unified concept. On this basis, it is likely that researchers face conceptual challenges when attempting to define shame, and this may result in a lack of clarity as to what is being measured across studies. This could explain the inconsistencies in the literature when looking at the link between shame and other concepts, such as violence or recidivism.

Across the nine studies that presented shame as a unified concept, shame was defined in two different ways. Five studies made use of Lewis' shame conceptualisation, stating that shame is a negative global evaluation of the entire self (Lewis, 1971). This definition was used in conjunction with the self-behaviour conceptualisation, suggesting that shame is unhelpful and leads to avoidance (Dearing et al., 2005; Lewis, 1971; Stuewig et al., 2009; Stuewig et al., 2010; Tangney et al., 2011; Tangney et al., 2014). It is important to note that these five studies were all authored in part by the same researcher, demonstrating that the author has opted to utilise their own conceptualisation of shame in each of these studies. Of the other 4 studies, 3 were found to explicitly use the evolutionary perspective put forward by Gilbert (Farmer & Andrews, 2009; Morisson & Gilbert, 2001; Wright & Gudjinsson, 2007). All of these studies suggested that shame led to a desire to hide or avoid. In 1 study (Shanahan, Jones & Thomas-Peter, 2011) the authors stated that shame is a condemnation of the global self in the eyes of the self and others. Out of the 8 studies reporting a single definition of shame, this is the only study that did not mention avoidance when conceptualising shame.

In summary, the results suggest that when conceptualising shame in forensic populations, it is mainly done using either the self/behaviour distinction or evolutionary theory of shame, both of which draw inspiration from Lewis's (1971) well recognised conceptualisation of shame. The key difference between these two conceptualisations is

that the self/behaviour definition focuses on unhelpful shame, in that it leads to avoidance or hiding, whereas although the evolutionary theory suggests shame could potentially lead to avoidance, its primary focus is on the positive evolutionary function of shame.

Through examination of conceptualisations of shame across forensic populations authors agree that it is an unpleasant emotion focusing on the self as flawed or inferior (e.g., Farmer & Andrews, 2009; Morisson & Gilbert, 2001; Wright & Gudjinsson, 2007). Some authors define shame according to an emotional response coupled with avoidance, whilst others only focus on the feeling of shame and suggest it could potentially lead to avoidance; however this is not a definite outcome. The inconsistencies or lack of clear definitions of shame in forensic literature could be explained by the suggestion that shame is not a single unified concept and is better understood in conjunction with other moral emotions (e.g. guilt and embarrassment). Another possibility is that inconsistencies across conceptualisations of shame used in the literature (e.g. self/behaviour distinction, evolutionary perspective) have led to conceptual confusion, resulting in researchers avoiding clear definitions of shame and further increasing inconsistencies in the definition of shame used in forensic populations.

The inconsistencies or lack of clear shame conceptualisations demonstrated across forensic populations are likely to mirror difficulties faced by researchers when attempting to measure shame. This finding highlights the need for researchers to fully define shame and then to communicate their definition clearly within the research paper.

### **Measurements of shame**

Through initial evaluation of instruments that measured shame in forensic populations, three categories emerged including: trait approaches, state approaches and a combination of both state and trait approaches. Trait approaches focused on the affective feeling of shame using adjectives (PFQ-2), focusing on others opinion of the self (OAS), or focusing on both self and others opinions (ISS, DES-IV). The PFQ-2 used shame



adjectives, to measure shame, reporting that the measure is predictive of depression, self-derogation and social anxiety. It focuses on personality traits relating to the construct of shame, using adjectives that could arguably be relevant to other moral emotions such as guilt or embarrassment. This means that the measure could potentially be measuring other negative personality traits, rather than shame in isolation.

The ISS measured shame by looking at both other people's negative, global attributions of the self, as well as the self's negative opinion of itself. This contrasted with the newer OAS measure, an adapted version of the ISS, which only focused on the other opinions of the self. Both scales demonstrated construct validity through correlations with depression and anxiety. An interesting finding across all trait approach measures was demonstrated by convergent validity. All trait approaches that reported construct validity compared their measure with other trait approach measures. The inconsistencies present in the shame literature could be rationalised through state and trait shame measuring different aspects of shame. This parallels conclusions drawn from researchers investigating state and trait anger (Farmer & Andrews, 2009; Hejdenberg & Andrews, 2011; Hoglund & Nicholas, 1995; Tangney, Wagner, Fletcher & Gramzow, 1992). These findings suggest that several different shame concepts are being measured in forensic populations, trait and state shame. It is therefore recommended that trait and state shame are examined separately to avoid inconsistencies in the forensic literature and forge clearer links between different aspects of shame and other important concepts such as violence or recidivism.

State approach measures (e.g. TOSCA-3, TOSCA-SD, ORSGS, Shame related emotions, Shame emotions) use scenario-based measures and ask participants how likely they are to respond in certain ways to difficult situations. These measures all used at least one item which was focused on avoidance or withdrawal. This is consistent with definitions suggesting that shame is conceptualised by both a feeling and an avoidance

behaviour. This finding is in line with the idea that state approaches focus on avoidance as a key aspect of shame whereas trait approaches do not. This may explain inconsistencies across the shame literature. All state approach measures apart from the Shame Emotions measure (Murphy & Harris, 2007; Murphy, 2013) used violence or anger to demonstrate construct validity. One possible theory is that state approaches measure shame and avoidance which in combination are unhelpful leading to anger or violence. Therefore, state approaches may not actually be measuring shame in isolation but could instead be investigating an unhelpful response to shame. This is consistent with researchers suggesting that the TOSCA measures motivation rather than emotion (for a full review see Giner-Sorolla, Piazza & Espinosa, 2011).

In both the Shame Emotions and Shame-Related Emotions measures, Braithwaite's (1989) Reintegrative Shaming Theory was used to understand the function of shame (Braithwaite, 1989; Harris, 2003, 2006; Murphy & Harris, 2007; Murphy, 2013). Braithwaite's theory suggests two aspects of shame; reintegrative shaming which promotes social integration and stigmatizing shaming which leads to withdrawal (Braithwaite, 1989). The focus on two moral pathways starting with the feeling of shame and leading to either withdrawal/avoidance or reparative action closely mirrors the definitions of shame and guilt demonstrated by Stuewig et al, (2010). However, unlike the TOSCA these two pathways of shame (with one suggesting that shame can be helpful) are in line with the constructionist theory of shame, suggesting that shame can be helpful under the right conditions (Leach & Cidam, 2015). These findings further emphasise the importance of conceptualising the aspect of shame measured and the utilisation of clear theoretical underpinnings.

### **Limitations and recommendations**

It is important to consider the limitations presented by the review and its findings. All measures were validated in western cultures and therefore it is unlikely that the

findings in the current review are comparable across cultures.

After conducting the initial search, researchers who created a measure of shame were contacted directly, with the aim to obtain further information concerning the validity and reliability of measures. However, this was met with varying degrees of success. The varied depth of responses from sources may have led to a bias in the information gained regarding the validity or reliability of measures.

The current review recommends that researchers should always conceptualise shame before attempting to measure it. Most of the studies measuring shame in forensic populations did not conceptualise shame before measuring it, potentially leading to inconsistencies in literature examining the relationship between shame and other constructs. Further, measures of shame that were used in forensic populations utilised well recognised theories (e.g. Lewis, 1971, Gilbert, 1997) to create measures. However, different aspects of the same theory were used in different ways leading to confusion about shame conceptualisations and how it can be measured. These findings also emphasise the need for more research to disentangle various aspects of shame. This will help to understand the relationship between shame and other constructs, such as recidivism, anger or violence.

## References

- Ahmed, E. (2001), 'Shame Management: Regulating Bullying', in Ahmed, E., Harris, N., Braithwaite, J. and Braithwaite, V., eds, *Shame Management through Reintegration*, 209–311. Cambridge: Cambridge University Press.
- Andrews, B. (1998). Methodological and definitional issues in shame research. *Shame: Interpersonal behavior, psychopathology, and culture*, 39-54.
- Andrews, B, Brewin, C.R, Rose, S., Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: the role of shame, anger, and childhood abuse. *Journal of Abnormal Psychology*, 109, 69–73. [doi:org/10.1037/0021-843X.109.1.69](https://doi.org/10.1037/0021-843X.109.1.69)
- Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. *British Journal of Clinical Psychology*, 41(1), 29-42.
- Bennett, D, S., Sullivan, M.W., Lewis, M. (2005). Young children's adjustment as a function of maltreatment, shame, and anger. *Child Maltreatment*, 10 (4), 311–323. doi: 10.1177/1077559505278619
- Braithwaite, J. (1989), *Crime, Shame and Reintegration*. Cambridge: Cambridge University Press.
- Braithwaite, V., & Braithwaite, J. (2001). Managing tax compliance: The evolution of the Australian Taxation Office compliance model. In *Tax administration in the 21st century*. Prospect Media Pty Ltd.
- Brazão, N., Da Motta, C., Rijo, D., do Céu Salvador, M., Pinto-Gouveia, J., & Ramos, J. (2015). Clinical change in anger, shame, and paranoia after a structured cognitive-behavioral group program: Early findings from a randomized trial with male prison inmates. *Journal of Experimental Criminology*, 11(2), 217-236.

- Campbell, J. S., & Elison, J. (2005). Shame coping styles and psychopathic personality traits. *Journal of Personality Assessment*, 84, 96-104.
- Cook, D. R. (1993). *The Internalized Shame Scale Manual*. Menomonie, WI: Channel Press (available from the author: Rt. 7, Box 270a, Menomonie, WI, 54751).
- Cook, D. R. (1994). *Internalized shame scale: professional manual*. Menomonie, WI: Channel Press.
- Cook, D. R. (1996). Empirical studies of shame and guilt: The internalized shame scale. I D. L. Nathanson (red.), *Knowing feeling: Affect, script and psychotherapy* (ss. 132-165).
- Cripps, J. E. (1997). *The Association Between the Neutralization of Self-Punishment. Guilt, and Psychopathy Among Extrafamilial Child Molesters* (Doctoral dissertation, Carleton University Ottawa).
- Dearing, R. L., Stuewig, J., & Tangney, J. P. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use. *Addictive behaviors*, 30(7), 1392-1404.
- Deffenbacher, J. L., Oetting, E. R., Thwaites, G. A., Lynch, R. S., Baker, D. A., Stark, R. S., ... & Eiswerth-Cox, L. (1996). State-trait anger theory and the utility of the trait anger scale. *Journal of Counseling Psychology*, 43(2), 131.
- Del Rosario, P. M., & White, R. M. (2006). The Internalized Shame Scale: Temporal stability, internal consistency, and principal components analysis. *Personality and Individual Differences*, 41(1), 95-103.
- Dyer, K., Dorahy, M., Corry, M., Black, R., Matheson, L., Coles, H., . . . Middleton, W. (2016). Comparing Shame in Clinical and Nonclinical Populations: Preliminary Findings. *Psychological Trauma: Theory, Research, Practice, and Policy*, Psychological Trauma: Theory, Research, Practice, and Policy, 2016.
- Easton, P., Entwistle, V. A., & Williams, B. (2010). Health in the 'hidden population' of people with low literacy. A systematic review of the literature. *BMC public health*, 10(1), 459.

- Farmer, E., & Andrews, B. (2009). Shameless yet angry: shame and its relationship to anger in male young offenders and undergraduate controls. *The Journal of Forensic Psychiatry & Psychology*, 20(1), 48-65.
- Fergus T. A., Valentiner, D. P., McGrath P. B., Jencius, S. (2010). Shame- and guilt-proneness: Relationships with anxiety disorder symptoms in a clinical sample. *Journal of Anxiety Disorders*, 24, 811–815.
- Gilbert, P. (1992). *Depression. The Evolution of Powerlessness*. London, New York: Routledge.
- Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology*, 70(2), 113-147.
- Gilbert, P., & McGuire, M. T. (1998). Shame, status, and social roles: Psychobiology and evolution. In *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 99-125). New York, NY: Oxford University Press.
- Gilbert, P., & Miles, J. (Eds.). (2014). *Body shame: Conceptualisation, research and treatment*. Suffolk, UK: Routledge.
- Gilbert, P., Pehl, J., & Allan, S. (1994). The phenomenology of shame and guilt: An empirical investigation. *British Journal of Medical Psychology*, 67(1), 23-36.
- Giner-Sorolla, R., Piazza, J., & Espinosa, P. (2011). What do the TOSCA guilt and shame scales really measure: Affect or action?. *Personality and Individual Differences*, 51(4), 445-450.
- Gilligan, J. (1996). Exploring shame in special settings: A psychotherapeutic study. In *Forensic psychotherapy: Crime, Psychodynamics and the offender patient* (Vol 2, pp. 475-490). London: Jessica Kingsley Publisher.
- Gilligan, J. (2000). Punishment and violence: Is the criminal law based on one huge mistake?. *Social Research*, 745-772.
- Giner-Sorolla, R., Piazza, J., & Espinosa, P. (2011). What do the TOSCA guilt and shame scales really measure: Affect or action?. *Personality and Individual Differences*, 51(4), 445-450.

- Goss, K., Gilbert, P., & Allan, S. (1994). An exploration of shame measures—I: The other as Shamer scale. *Personality and Individual differences*, 17(5), 713-717.
- Goss, K., & Allan, S. (2009). Shame, pride and eating disorders. *Clinical Psychology & Psychotherapy*, 16, 303–316.
- Hanson, R. K. (1996, November). Coping with culpability. Paper presented at the meeting of the Association for the Treatment of Sexual Abusers, Chicago.
- Hanson, R. K., & Tangney, J. P. (1996). The test of self-conscious affect—socially deviant populations (TOSCA-SD). *Unpublished corrections research, Department of the Solicitor General of Canada, Ottawa, Ontario, Canada*.
- Harder, D. W., & Lewis, S. J. (1987). The assessment of shame and guilt. *Advances in personality assessment*, 6, 89-114.
- Harder, D. W., Cutler, L., & Rockart, L. (1992). Assessment of shame and guilt and their relationships to psychopathology. *Journal of personality assessment*, 59(3), 584-604.
- Harder, D. W., Rockart, L., & Cutler, L. (1993). Additional validity evidence for the harder personal feelings questionnaire-2 (PFQ2): A measure of shame and guilt proneness. *Journal of clinical psychology*, 49(3), 345-348.
- Harder, D. H., & Zalma, A. (1990). Two promising shame and guilt scales: A construct validity comparison. *Journal of personality assessment*, 55(3-4), 729-745.
- Harper, F. W., Austin, A. G., Cercone, J. J., & Arias, I. (2005). The role of shame, anger, and affect regulation in men's perpetration of psychological abuse in dating relationships. *Journal of Interpersonal Violence*, 20(12), 1648-1662.
- Harper, F.W.K., Arias, I. (2004). The role of shame in predicting adult anger and depressive symptoms among victims of child psychological maltreatment. *Journal of Family Violence*, 19 (6), 367–375. doi: 10.1007/s10896-004-0681-x
- Harris, N. (2003) 'Reassessing the Dimensionality of the Moral Emotions', *British Journal of Psychology*, 94: 457 – 73.

- Harris, N. (2006). 'Reintegrative Shaming, Shame and Criminal Justice'. *Journal of Social Issues*, 62, 327 – 46.
- Hejdenberg, J., & Andrews, B. (2011). The relationship between shame and different types of anger: A theory-based investigation. *Personality and Individual Differences*, 50(8), 1278-1282.
- Hoglund, C. L., & Nicholas, K. B. (1995). Shame, guilt, and anger in college students exposed to abusive family environments. *Journal of Family Violence*, 10, 141–157.
- Hosser, D., Windzio, M., & Greve, W. (2008). Guilt and Shame as Predictors of Recidivism A Longitudinal Study With Young Prisoners. *Criminal Justice and Behavior*, 35(1), 138-152.
- Howells, K. (2004). Anger and its link to Violent Offending. *Journal of Psychiatry, Psychology and Law*, 11 (2), 189-196. doi:10.1375/pplt.2004.11.2.189
- Izard, C. E. (1993). *The Differential Emotions Scale: DES IV-A;[a Method of Measuring the Meaning of Subjective Experience of Discrete Emotions]*. University of Delaware.
- Izard C. E. (1971) *The Face of Emotion*. Appleton-Century-Crofts, New York.
- Izard, C. E., Libero, D. Z., Putnam, P., & Haynes, O. M. (1993). Stability of emotion experiences and their relations to traits of personality. *Journal of personality and social psychology*, 64(5), 847.
- Jackson, A. (2009). The impact of restorative justice on the development of guilt, shame, and empathy among participants in a victim impact training program. *Victims & Offenders*, 4(1), 1-24.
- Jackson, A. L., & Bonacker, N. (2006). The effect of victim impact training programs on the development of guilt, shame and empathy among offenders. *International Review of Victimology*, 13(3), 301-324.



- Kaufman, G. (1989) *The Psychology of Shame*. New York: Springer.
- Keen, S. (2008). *Perceived Social Rank, Social expectation, shame and general emotionality within psychopathy (Doctorate thesis, University College London, London, England)*. Retrieved from <http://discovery.ucl.ac.uk/1444243/1/U591545.pdf>
- Laithwaite, H., O'Hanlon, M., Collins, P., Doyle, P., Abraham, L., Porter, S., & Gumley, A. (2009). Recovery after psychosis (RAP): A compassion focused programme for individuals residing in high security settings. *Behavioural and Cognitive Psychotherapy*, 37(05), 511-526.
- Leach, C., Cidam, A., & Smith, Eliot R. (2015). When Is Shame Linked to Constructive Approach Orientation? A Meta-Analysis. *Journal of Personality and Social Psychology*, 109(6), 983-1002.
- Lewis, H. B. (1971). *Shame and Guilt in Neurosis*. New York (International Universities Press) 1971.
- Lowinger, T., & Solomon, Z. (2004). PTSD, guilt, and shame among reckless drivers. *Journal of Loss and Trauma*, 9(4), 327-344.
- Milligan, R. J., & Andrews, B. (2005). Suicidal and other self-harming behaviour in offender women: The role of shame, anger and childhood abuse. *Legal and Criminological Psychology*, 10(1), 13-25.
- Morrison, D., & Gilbert, P. (2001). Social rank, shame and anger in primary and secondary psychopaths. *Journal of Forensic Psychiatry*, 12(2), 330-356.
- Murphy, K., & Harris, N. (2007). Shaming, shame and recidivism a test of reintegrative shaming theory in the white-collar crime context. *British Journal of Criminology*, 47(6), 900-917.
- Murphy, K., & Helmer, I. (2013). Testing the importance of forgiveness for reducing repeat offending. *Australian & New Zealand Journal of Criminology*, 46(1), 138-156.

- Nathanson, D. L. (1992). *Shame and pride: Affect, sex, and the birth of the Self*. New York: W.W. Norton & Company.
- Paulhus, D. L., Robins, R. W., Trzesniewski, K.H., & Tracy, J.L. (2004). Two replicable suppressor situations in personality research. *Multivariate Behavioral Research*, 39, 303–328. [doi.org/10.1207/s15327906mbr3902\\_7](https://doi.org/10.1207/s15327906mbr3902_7)
- Perez, M. A. (2005). *The cycle of violence: Shame and attachment issues among violent perpetrators (Master's thesis, University of California, Long Beach, USA)*. Retrieved from <http://search.proquest.com.ezproxy.is.ed.ac.uk/docview/305365211/>
- Retzinger, S. M., & Scheff, T. J. (1996). Strategy for community conferences: Emotions and social bonds. *Restorative justice: International perspectives*, 315-36.
- Roseman, C. P., Ritchie, M., & Laux, J. M. (2009). A restorative justice approach to empathy development in sex offenders: An exploratory study. *Journal of Addictions & Offender Counseling*, 29(2), 96-109.
- Shanahan, S., Jones, J., & Thomas-Peter, B. (2011). Are you looking at me, or am I? Anger, aggression, shame and self-worth in violent individuals. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 29(2), 77-91.
- Sklar, M., Groessl, E. J., O'Connell, M., Davidson, L., & Aarons, G. A. (2013). Instruments for measuring mental health recovery: a systematic review. *Clinical psychology review*, 33(8), 1082-1095.
- Spice, A., Viljoen, J. L., Douglas, K. S., & Hart, S. D. (2015). Remorse, psychopathology, and psychopathy among adolescent offenders. *Law and human behavior*, 39(5), 451.
- Stuewig, J., Tangney, J. P., Heigel, C., Harty, L., & McCloskey, L. (2010). Shaming, blaming, and maiming: Functional links among the moral emotions, externalization of blame, and aggression. *Journal of Research in Personality*, 44(1), 91-102.

- Stuewig, J., Tangney, J. P., Mashek, D., Forkner, P., & Dearing, R. (2009). The moral emotions, alcohol dependence, and HIV risk behavior in an incarcerated sample. *Substance use & misuse*, 44(4), 449-471.
- Tangney, J. P. (1991). Moral affect: The good, the bad, and the ugly. *Journal of Personality and Social Psychology*, 61, 598-607.
- Tangney, J.P., & Dearing, R. (2002). Shame and Guilt. New York: Guilford.
- Tangney, J.P., Dearing, R., Wagner, P.E., & Gramzow, R. (2000). *The Test of Self-Conscious Affect. 3 (TOSCA-3)*. Fairfax, VA: George Mason University.
- Tangney, J., Stuewig, J., & Hafez, L. (2011). Shame, guilt, and remorse: Implications for offender populations. *Journal of Forensic Psychiatry & Psychology*, 22(5), 706-723.
- Tangney, J. P., Stuewig, J., & Martinez, A. G. (2014). Two faces of shame the roles of shame and guilt in predicting recidivism. *Psychological science*, 25(3), 799-805.
- Tangney, J. P., Stuewig, J., Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual Review of Psychology*, 58, 345–372
- Tangney, J. P., Stuewig, J., Mashek, D., & Hastings, M. (2011). Assessing jail inmates' proneness to shame and guilt: Feeling bad about the behavior or the self?. *Criminal justice and behavior*, 0093854811405762.
- Tangney, J. P., Wagner, P., Fletcher, C., & Gramzow, R. (1992). Shamed into anger? The relation of shame and guilt to anger and self-reported aggression. *Journal of personality and social psychology*, 62(4), 669.
- Tangney, J. P., Wagner, P., & Gramzow, R. (1989). *The Test of Self-Conscious Affect*. Fairfax, VA: George Mason University.
- Terwee, C. B., Bot, S. D., de Boer, M. R., van der Windt, D. A., Knol, D. L., Dekker, J., ... & de Vet, H. C. (2007). Quality criteria were proposed for measurement properties of health status questionnaires. *Journal of clinical epidemiology*, 60(1), 34-42.

- Tilghman-Osborne, C., Cole, D. A., & Felton, J. W. (2010). Definition and measurement of guilt: Implications for clinical research and practice. *Clinical Psychology Review*, 30(5), 536-546.
- Velotti, P., Garofalo, C., Bottazzi, F., & Caretti, V. (2016). Faces of shame: implications for self-esteem, emotion regulation, aggression, and well-being. *The Journal of Psychology*, 151(2), 171-184.
- Velotti, P., Elison, J., & Garofalo, C. (2014). Shame and aggression: Different trajectories and implications. *Aggression and Violent Behavior*, 19(4), 454-461.
- Ward, T., Hudson, S. M., & Marshall, W. L. (1994). The abstinence violation effect in child molesters. *Behaviour Research and Therapy*, 32(4), 431-437.
- Wright, K., & Gudjonsson, G. H. (2007). The development of a scale for measuring offence-related feelings of shame and guilt. *The Journal of Forensic Psychiatry & Psychology*, 18(3), 307-316.
- Wright, K., Gudjonsson, G. H., & Young, S. (2008). An investigation of the relationship between anger and offence-related shame and guilt. *Psychology, Crime & Law*, 14, 415-423.
- Wright, K., & Gudjonsson, G. H. (2007). The development of a scale for measuring offence-related feelings of shame and guilt. *The Journal of Forensic Psychiatry & Psychology*, 18(3), 307-316.
- Wright, K., Gudjonsson, G. H., & Young, S. (2008). An investigation of the relationship between anger and offence-related shame and guilt. *Psychology, Crime & Law*, 14(5), 415-423.
- Youngstrom, E. A., & Green, K. W. (2003). Reliability generalization of self-report of emotions when using the Differential Emotions Scale. *Educational and Psychological Measurement*, 63(2), 279-295.

## Appendix A: Guidance for publication in The International Journal of Forensic Mental Health

The International Journal of Forensic Mental Health publishes original scholarship related to law and mental health. The journal is international and interdisciplinary, and values original research submissions, both quantitative and qualitative in nature, as well as literature reviews, case studies and theoretical articles. There is no maximum page limit or word count, but manuscripts should conform to the style requirements outlined in the Publication Manual of the American Psychological Association (currently in its 6th edition). The style requirements for this journal are provided below.

**Manuscript Submission.** *International Journal of Forensic Mental Health* receives all manuscript submissions electronically via the ScholarOne Manuscripts website (<http://mc.manuscriptcentral.com/UFMH>). ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, as well as facilitating the review process and internal communication between authors, editors and reviewers via a web-based platform. For ScholarOne Manuscripts technical support, you may contact them by e-mail or phone support via <http://scholarone.com/services/support/>. If you have any other requests please contact the editor of the journal, Dr. Barry Rosenfeld ([rosenfeld@fordham.edu](mailto:rosenfeld@fordham.edu)). Additional information on the ScholarOne system is available in the [guide for ScholarOne authors](#).

Please note that the *International Journal of Forensic Mental Health* uses [CrossCheck™](#) software to screen papers for unoriginal material. By submitting your paper to the *International Journal of Forensic Mental Health* you are agreeing to any necessary originality checks your paper may have to undergo during the peer review and production processes.

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. As an author, you are required to secure permissions if you want to reproduce any figure, table, or extract from the text of another source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source). All accepted manuscripts, artwork, and photographs become the property of the publisher.

**Recommending Reviewers.** The manuscript portal will request the names of potential reviewers. These should be individuals who you believe are qualified and appropriate to review the manuscript in an objective and informed manner. They should not be friends or collaborators, who are likely to be aware of your work and/or identity, and unable to objectively judge the submission. Typically these will be individuals that have published on the topic (e.g., authors that have been cited in the Introduction to your paper). You need not obtain permission from potential reviewers in advance. They will simply be added to our list of potential reviewers; they may or may not be contacted by the Editor/Associate Editor that processes your manuscript. If there are potential reviewers that you believe will not judge your work objectively, these individuals can also be identified during the submission process (i.e., as "non-preferred reviewers").

**Preparing Your Manuscript.** The *International Journal of Forensic Mental Health* requires that all manuscripts be prepared in accordance with the APA Publication Manual, 6th edition. All parts of the manuscript should be typed, double spaced, in 12-point font, and with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Manuscripts should be prepared for blind review, with a separate title page uploaded separately.

**Title Page:** The title page (which is not sent to reviewers, to preserve blind peer review) should contain only the title (preferably no more than 12 words), the author(s) names and the institutional affiliation for each author. Author credentials (e.g., degrees), mailing addresses, or acknowledgements should NOT be included on the title page. In addition, the title page should include a “Running Head” that will accompany the manuscript once typeset. The Running Head should not exceed 3-4 words.

**Abstract:** Each manuscript must include an Abstract (on a separate page) summarizing the content and key findings. Abstracts are NOT structured (i.e., are comprised of a single paragraph, without subheadings), and should not exceed 250 words. Avoid abbreviations, diagrams, and references. Some specificity regarding the study findings is also useful (e.g., some, but limited data rather than simply a statement that “significant associations were found between”).

The Abstract page should include 4-5 keywords indicating the primary focus of the manuscript (to facilitate search engines). Keywords should not be overly narrow or specific, but should provide sufficient information to enable search engines to identify the paper.

### **Manuscript Body:**

**Headings.** The heading structure for all sections follows the same top-down progression, regardless of how many subsections are contained within any section. See below for an example of the indentation, font, and punctuation that should be associated with each level of heading.

## **Introduction Approaches to Violence Risk Assessment**

Subheadings are NOT required in the Introduction, but when used, they must conform to the APA standards.

### **Method**

The number and depth of subheadings within the Method section will depend on length and complexity. Many Method sections will simply include a description of the participants and setting where they were drawn, along with a summary of the sample characteristics – with no subheadings needed. For longer sections, consider using subheadings (and even sub- subheadings) to clarify the text. Most Method sections will include, at a minimum, subheadings for Participants, Procedure, and Statistical Analysis

#### **Participants**

Note that this level of subheading should use “title case”, where most words are capitalized. The text for this level of subheading should be indented, below the subheading. All

paragraphs in the manuscript should be indented, with no spaces between paragraphs. **Sample characteristics.** Note that this level of subheading (if used) should only capitalize the first word. The text for this level of subheading begins on the same line.

## **Measures**

Note that many studies will not need a separate subheading for measures, but rather will include this information in the Procedure section.

**Instruments used to assess violence risk.** Some studies will be sufficiently complex such that subheadings for predictors and outcome variables are useful.

## **Procedure**

This section **MUST** include information about ethics approval for the study (assuming the paper describes a research study for which ethics approval is appropriate).

## **Statistical Analysis Plan**

A brief summary of the statistical analyses, and how they will address the study questions and variables, is useful in helping guide the reader through the Results that will follow.

## **Results**

Note that subheadings within the Results (and Discussion) will depend on content. See the paragraph below about formatting statistics.

## **Discussion**

The Discussion section should **DISCUSS** the study findings, not simply repeat them. What are the implications, how much we understand contradictory or counterintuitive findings? **Limitations**

A discussion of study limitations – not simply a sentence listing them, is essential to interpreting the data from virtually every published study.

## **Conclusions**

**Reporting Statistics.** All statistics should be reported in accordance with APA style. In general, this means italicizing the actual statistic (*F*), including the d.f., and giving exact *p* values ( $p = .03$ , not  $p < .05$ ). A *p* value below .001 should be reported as  $p < .001$ , not  $p = .00$ . Most statistics should include 2 decimal places, but in some cases one may be sufficient (e.g., percentages, means, etc). Three decimal places should be limited to situations where small gradations are meaningful (e.g.,  $p = .002$ , or for describing fit statistics for multivariate models, where small differences are relevant). Whenever possible, effect size estimates and 95% confidence intervals should be provided. Statistics that are presented in a table need not be repeated extensively in the text, unless there is a logical reason to do so (e.g., to highlight key findings, or identify the handful of significant findings from a larger pool of analyses).

However, you should refer to the table in the text and emphasize particular data in your narrative that may help the reader to interpret your findings. Examples of how to report inferential statistics in the body of your manuscript are provided below.

## □ Correlations

To test the hypothesis that positive associations would exist between psychopathy and violence risk, Pearson correlation analyses were performed and can be found in Table 1. Contrary to predictions, although PCL-R Factor 1 was significantly related to violence risk ( $r = .37, p < .01$ ), PCL-R Factor 2 was not ( $r$

$= .10, p = .29$ ).

### • ANOVA

Mean PCL-R scores differed significantly across risk categories,  $F[5, 38] = 4.01, p = .01$ .

Significant differences between risk categories were revealed in pair-wise comparisons.

Participants with low risk ratings had significantly lower psychopathy scores ( $M = 5, SD = 1.2$ ) than those with moderate risk ratings ( $M = 10, SD = 3.3$ ) and those with high risk ratings ( $M = 24, SD = 4.1$ ).

- Regression: When entered into a regression, age, number of prior arrests, and number of prior hospitalizations predicted violence risk rating  $F[3,44] = 2.36, p = .02$ , accounting for 27.3% of the citations and the reference list should be prepared in accordance with the APA Publication Manual, 6th edition.

In the body of the manuscript, cite the reference by author and publication date. Examples are provided below.

- One work by one author: (Smith, 1983)
- One work by multiple authors: (Smith, Jones, & Miller, 1983)
  - For subsequent citations, one work by three or more authors can be cited as: (Smith et al., 1983)
- One work by six or more authors: (Smith et al., 1983)
- Two or more works within the same parentheses
  - Two or more works by the same author should be arranged by year of publication: (Smith, 1983, 1987)
  - Identify works with the same author and same publication date with suffixes: (Smith, 1987a, 1987b)
  - Two or more works by different authors should be organized alphabetically, as they appear in the reference list: (Hart & Steinman, 2000; Smith, Jones, & Miller, 1987)

The reference list should be organized alphabetically and should come at the end of the article. A general outline of the entry is as follows: Author, A. A., Author, B. B., & Author, C. C. (year). Title of article. *Title of periodical*, volume, pp-pp. doi: xxxxx. More specific examples are provided below.

## □ Journal Article:

Tsai, M., & Wagner, N. N. (1978). Therapy groups for women sexually molested as children.

*Archives of Sexual Behaviour*, 7, 417-427. doi: 10.1037/0096-3445.134.2.258 □ Book:



Millman, M. (1980). *Such a pretty face*. New York: W.W. Norton.

□ Book chapter:

Zirkel, S. (2000). Social intelligence: The development and maintenance of purposive behavior. In R. Bar-On & J. D. Parker (Eds.), *Handbook of Emotional Intelligence* (pp. 3-27). San Francisco, CA: Jossey-Bass.

Examples of other types of references should refer to the Style Manual for the American

**Illustrations.** Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

300 dpi or higher

Sized to fit on journal page

EPS, TIFF, or PSD format only

Submitted as separate files, not embedded in text files

**Color Illustrations.** Color art will be reproduced in color in the online publication at no additional cost to the author. Color illustrations will also be considered for print publication; however, the author will be required to bear the full cost involved in color art reproduction. Color reprints can only be ordered if print reproduction costs are paid. Print Reproduction: \$900 for the first page of color; \$450 per page for the next three pages of color. A custom quote will be provided for articles with more than four pages of color. Art not supplied at a minimum of 300 dpi will not be considered for print.

**Tables and Figures.** Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files (appended to the end of the manuscript, in APA style). A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet. Tables MUST be a) properly formatted, b) coherently organized, c) legible, and d) relevant. Any acronyms or abbreviated terms must be spelled out in the Note below the table (even if the acronyms have already been spelled out in the body of the manuscript). Tables should NOT simply be cut-and-pasted computer output. Tables that are completely redundant with the text are typically unnecessary. Consider whether each table (and figure) provides important information that complements the text.

**Proofs.** Page proofs are sent to the designated author using Taylor & Francis' Central Article Tracking System (CATS). They must be carefully checked and returned within 48 hours of receipt.

**Reprints and Issues.** Reprints of individual articles are available for order at the time authors review page proofs. A discount on reprints is available to authors who order before print publication. Each corresponding author will receive 1 complete issues in which the article publishes and a complimentary PDF. This file is for personal use only and may not be copied and

disseminated in any form without prior written permission from Taylor and Francis Group, LLC.

Authors for whom we receive a valid email address will be provided an opportunity to purchase reprints of individual articles, or copies of the complete print issue. These authors will also be given complimentary access to their final article on *Taylor & Francis Online*.

**Open Access.** Taylor & Francis Open Select provides authors or their research sponsors and funders with the option of paying a publishing fee and thereby making an article fully and permanently available for free online access – *open access* – immediately on publication to anyone, anywhere, at any time. This option is made available once an article has been accepted in peer review. Details can be found on the journal's Taylor & Francis webpage.

## Appendix B: Criteria used to evaluate the psychometric properties of the measures of shame

Type	Definition	Criteria	Absent (0) Partially present (0.5) Present (1)
Conceptual clarity	Is shame adequately described and linked to evidence or theory?	A clear description of shame is provided with a theoretical model or evidence.	
Content validity	Are the items in the measure sampling the domain of interest (shame)?	A clear description of the concept being measured and item selection.	
Internal consistency	Are the individual items in the measure consistent with each other?	Internal consistency above 0.7 using Chronbach's alpha.	
Convergent Validity	Does the measure correlate to existing measures of shame?	The correlation is above 0.7.	
Construct Validity	Does the measure correlate with other constructs in a theoretically expected way?	Scores on the measure correlate with other theoretically linked constructs in an expected way.	
Test- Retest Reliability	Does the measure produce consistent outcomes?	Test-retest reliability produces a weighted Kappa of >.70	
Interpretability	Can qualitative meaning be assigned to the test scores?	Means and standard deviations presented for two populations including at least one forensic population.	

**“What made me change was being given an opportunity to change my life and for somebody to say to me: I am a good person, I am loved”: Shame, Compassion, Attachment and Violence in Female Offenders**

Emma Macey, NHS Forth Valley, Forensic Clinical Psychology Service & University of Edinburgh, Scotland, Department of Clinical Psychology.

Mette Kreis, NHS Forth Valley, Forensic Clinical Psychology Service.

Ethel Quayle, University of Edinburgh, Scotland, Department of Clinical Psychology.

Emily Newman, University of Edinburgh, Scotland, Department of Clinical Psychology.

Corresponding author: Emma Macey, NHS Forth Valley, Forensic Clinical Psychology Service, Westburn building, Falkirk Community Hospital, Westburn Avenue, Falkirk, FK1 5SU. Tel: 01324 616211 Email: emma.macey@nhs.net

As prepared for The International Journal of Forensic Mental Health (see Appendix A)

7,517 words

## **Abstract**

Some research shows that shame is related to violence or recidivism. Currently, there is limited research that investigates this relationship in female offenders. Therefore, the purpose of this study was to explore shame and violence in female offenders. A social constructivist grounded theory approach was applied to the narratives of eight violent female offenders involved in Criminal Justice services across Scotland. Interviews focused on thoughts, feelings and life experiences in relation to shame and violent behaviours. A model hypothesising a relationship between shame and violence suggested that childhood victimisation in the context of insecure attachment led to difficulties regulating emotions including shame. The absence of compassionate, positive and secure relationships may have led to the use of unhelpful emotion regulation strategies including self-harm, substance misuse and violence; these strategies formed a negative self-perpetuating cycle. It appeared that this vicious cycle could be broken through development of secure, positive and compassionate relationships in later life. This led to the employment of more helpful coping strategies, such as social support, to regulate shame and other negative emotions. Findings suggest shame and attachment may be important targetable factors, that could help to address the unique needs of female offenders and inform treatment and service planning.

**Keywords: Shame, Female, Offender, Violence, Attachment**

Female offenders have an extremely high level of complex health and social needs, some of which are distinct from those of their male counterparts. When conducting life history interviews with 115 female prisoners in America, it was revealed that half of the participants met the lifetime diagnostic criteria for a serious mental illness. 51% of subjects met the criteria for Post- Traumatic Stress Disorder (PTSD), and 85% met the criteria for substance use disorder (Dehart, Lynch, Belknap, Dass-Brailsford & Green, 2014). Levels of mental illness (e.g. anxiety, psychosis, PTSD, depression, self-harm and suicidality) are higher in female offenders than the general population and in male offenders (Fazel & Seewald, 2012; O'Brien, Mortimer, Singleton & Meltzer, 2001; Singleton, Meltzer, Gatward, Coid & Deasy, 1998). Across 11 prisons in England, 47.9% of female prisoners were found to be prescribed one or more psychotropic medicines for mental health problems, compared to 16.9% of male prisoners (Hassan et al., 2014). Research is required that focuses on the complex health and social needs present in female offenders and their contribution to offending behaviour (Blanchette & Brown, 2006; Fazel, Bains & Dolls, 2006; Light, Grant & Hopkins, 2013; McClellan, Farabee & Crouch, 1997; O'Brien et al., 2001).

It has been suggested that the increased levels of mental health problems found amongst female offenders may be related to higher rates of victimisation experiences and insecure attachment (DeHart et al., 2014; Gelsthorpe, Sharpe & Roberts, 2007; Lynch, DeHart, Belknap & Green, 2013; Messina & Grella, 2006; Winham et al., 2015; Zlotnick et al., 2008). Attachment theory states that when a primary caregiver is consistent and attuned to the child's needs, they can provide a secure base for the child to explore their surroundings (Bowlby, 1969, 1973 & 1980). Based on these experiences of the responsiveness and availability of their primary care-giver, the child will then develop an internal working model of relationships as safe and available. This secure attachment will support the child's resilience to stress in later life (Cicchetti, Toth & Lynch, 1995).

However, when a primary caregiver cannot be sensitive and responsive to a child (e.g. childhood victimisation such as childhood neglect, or physical, sexual or emotional abuse), it is more likely that the child will develop a working model of relationships as insecure (Friedric, 2002). Insecure attachment can be conceptualised along two relational dimensions: anxiety or fear of abandonment, or through avoidance of close relationships (Brennan, Clark & Shaver, 1998).

High levels of insecure attachment have been shown to partially mediate the relationships between childhood victimisation and psychological distress (Winham et al., 2015). Therefore, if mental health problems relate to insecure attachment, victimisation or trauma, it is vital to address an individual's trauma experiences when engaging constructively with their mental health problems. This is consistent with research that emphasises the importance of using a trauma-informed intervention model with female offenders (e.g., Covington & Bloom, 2006).

Existing rehabilitation models are primarily based on risk management models founded on theoretical models of male offending, rather than encompassing the criminogenic (i.e. treatable, dynamic risk factors for reoffending) and non-criminogenic (needs not associated with offending, or a reduction in recidivism) needs that may be specific to women (Andres, Bonta & Wormith, 2006). There is limited research investigating the specific needs of female offenders (Blanchette & Brown, 2006; De Vogel & Nicholls, 2016; De Vogel, Stam, Bouman, Ter Horst & Lancel, 2016). To prevent recidivism, it is firstly expedient to fully comprehend the distinct needs of women to facilitate the development of their skills, confidence and engagement with treatment (Blanchette & Brown, 2006). To better understand these needs, research that focuses particularly on both criminogenic and non-criminogenic needs (Moffat, 2005) is required.

The number of female prisoners has increased by 50% worldwide since 2000, compared with a 20% increase in male prisoners (Walmsley, 2015). This significant

growth in the female prison population is not well understood and highlights the importance of conducting research specifically within a female context. The importance of targeting underlying factors linked to women's offending, such as mental health, substance misuse and parental responsibilities, has been well established (Blanchette & Brown, 2006). This has led to increased attention on needs and risks of women offenders; consequently the Commission on Women Offenders (CWO, 2012) was established by the Scottish Government and tasked with making recommendations for improving outcomes for women in the criminal justice system. The report acknowledges gender differences in offenders stating that female offenders are a lower risk to public safety, have higher mental health and drug problems and are at higher risk of past and present victimisation, sexual and physical abuse. The CWO therefore concluded that to reduce reoffending and improve outcomes for communities, both services and programmes need to be tailored to meet the unique needs of women offenders. This has led to changes in the female custodial estate across Scotland. For example, it has been announced that the plans for a new female prison in Inverclyde have been rejected and replaced with plans to invest in smaller regional community based facilities instead (Scottish Government, 2015). Community based alternatives are likely to have several positive outcomes, including; reducing economic costs, improving the lives of both offenders and their dependents and reducing recidivism (Lawlor, Nicholls & Sanfilippo, 2008). These changes across custodial estates are likely to increase the number of female offenders worldwide living within communities and highlights the importance of conducting research with community-based female offenders, to help shape the treatment options made available and inform evidence-based interventions (Bartlett et al, 2015). One area that has received sustained attention for its potential role in rehabilitation is shame, which will be discussed in further detail below (e.g., Hosser, Windzio & Greve, 2008; Tangney, Stuewig & Hafez, 2011;).



## **Shame**

Lewis (1971) suggests that shame is an experience felt in response to a transgression whereby the entire self is viewed as bad. Lewis states that shame arises in the context of real or imagined self-other comparisons, resulting in a negative evaluation of the self and feelings of powerless, worthless or inferiority. This leads to a sense of self exposure and a desire to escape or hide. Lewis (1971) was the first person to distinguish between the moral emotions of shame and guilt suggesting that guilt focused on a negative evaluation of a specific behaviour, whereas shame emphasised a negative evaluation of the global self. Although shame and guilt are both negative emotions the emphasis on the self, elicited by shame lead to intra-psychic pain, because the individual's core self is at stake. Many researchers have utilised Lewis' (1971) definition of shame especially when attempting to differentiate shame from guilt (e.g. Tangney & Dearing, 2002). Therefore, for the purpose of the current study Lewis' (1971) definition of shame will be used.

Research has consistently demonstrated that numerous psychological difficulties and disorders are linked with the experience of shame. These include anxiety, eating disorders, depression, low self-esteem, PTSD and suicidal ideation (Andrews, Brewin, Rose & Kirk, 2000; Castilho, Pinto-Gouveia & Duarte, 2017). Shame has also been associated with experiences of complex trauma (Courtois, 2004), which are highly prevalent in female offenders (Carlson & Shafer, 2010).

Shame is usually accompanied by a sense of smallness, worthlessness and powerlessness (Tangney, Stuewig & Mashek, 2007). It has also been conceptualised as a social emotion, whereby the self is pictured as inadequate through the perspective of another, more powerful, capable and rejecting person (Gilbert, Pehl & Allan, 1994). The self is viewed as unacceptable by others, and the attributes of the self that construct this

view are infallible, leading to a desire to hide from the social world. This results in feelings of frustration, rage and fury against the critical other (Tangney et al., 2007).

Although the definition of shame varies greatly across the literature, the commonality throughout is feeling flawed or inferior (e.g. Elison, 2005; Gilbert, 1998 Tangney et al., 2011). Gilligan (2003) draws a link between shame and violence, stating that early victimisation experiences, such as childhood neglect, physical or sexual abuse, can lead to overwhelming shame and low self-esteem. He states that violence is used to ward off feelings of shame and humiliation, replacing these with the opposite: pride and self-respect. It is therefore unsurprising that past research consistently demonstrates that a proclivity for shame is linked to anger and hostility, which is related to violent offending (Andrews et al., 2000; Bennett, Sullivan & Lewis, 2005; Harper & Arias, 2004; Paulhus, Robins, Trzesniewski & Tracy, 2004; Tangney & Dearing, 2002; Tangney et al., 2011; Howells, 2011).

Being prone to shame has also been associated with an increased risk of recidivism (Hosser et al., 2008). However, more recently it has been suggested that shame is multifaceted, and this tendency is only linked to recidivism when it is externalised (Tangney, Stuewig & Martinez, 2014). The inconsistencies across the literature which links shame to violence may highlight difficulties with the conceptualisation and measurement of shame. Leach & Cidam (2015) state that forensic literature investigating shame has tended to focus only on the unhelpful aspects of shame, biasing the literature. The social constructive approach, suggests shame can be helpful if the person perceives that the damage is both 'fixable' and 'manageable'. In this context, shame can lead to constructive approach behaviours such as apologising, helping or co-operating with others (Leach & Cidam, 2015). Forensic literature may focus on 'unhelpful' shame because a high proportion of offenders believe the self is 'bad' and 'unfixable' and therefore shame may often be unhelpful in this population.

A large proportion of male prisoners have experienced repeated humiliation and shame through verbal, emotional and physical abuse (Gilligan, 2003). These experiences of abuse are characterised as the clearest method of communicating to a child that they are not wanted or loved and that the self is bad or unfixable. This then heightens feelings of shame, which impact the individual's capacity to love and empathise with themselves and others. It has been suggested that early shame experiences could be recorded in memory and used as a reference point to identify the self in later life, increasing vulnerability to psychopathology (Pinto-Gouveia & Matos, 2011).

Criticism from another, particularly if considered by the self to be valid, can often lead to the experience of shame (Gilbert, 1998; Tangney, 1995). In this circumstance, individuals may feel personally shamed but may also feel angry, externalising the blame towards the critical other, leading to violence (Tangney, Miller, Flicker & Barlow, 1996; Tedeschi & Felson, 1994). Individuals with early victimisation experiences may also use violence as a coping strategy to avoid intolerable feelings of shame, replacing these with opposing feelings of pride and self-worth. This strategy may be used in any situation that elicits the feeling of shame (Gilligan, 2003).

This concept may also be particularly relevant to female offenders, as past research has demonstrated high levels of interpersonal violence experienced both in child and adulthood (Carlson & Shafer, 2010). While there is limited research that directly investigates shame in female offenders, a previous model based on females in a substance misuse service suggests that shame may be relevant to female offending (Kreis, Gillings, Svanberg & Schwannauer, 2016). The model suggests that for some women, substance misuse may begin within the context of abusive and rejecting parenting, resulting in unmet psychological needs, such as feeling loved and connected to others, which then leads to insecure attachment. Insecure attachment may lead to the use of substances to regulate painful emotions, such as shame, or offending to fund drug misuse. The model

suggests some women use substances to regulate emotions, however, it does not discuss the other ways in which women could regulate feelings of shame, and what the impact of this is on their risk of re-offending. The study also highlights the need to investigate the role of shame and trauma in relation to offending behaviour in different female offender populations, specifically violent female offenders.

The current literature emphasises that female offenders have complex life histories and that early victimisation experiences are linked with high levels of shame (Bennett, Sullivan & Lewis, 2010; DeHart, Lynch, Belknap, Dass-Brailsford & Green, 2014; Gelsthorpe et al., 2007; Feiring, Taska & Lewis, 1996; Lynch et al., 2013; Messina & Grella, 2006; Stuewig & McCloskey, 2005; Zlotnick et al., 2008;). Some research has demonstrated a link between shame and violence (Gilligan, 2003; Tangney et al., 1996; Tedeschi & Felson, 1994), however this has not been explicitly investigated in a population of female offenders.

Recognising this discontinuity in the literature at present, the aim of this study was to explore the notion of shame and its presence in violent female offenders, using grounded theory methods. The role of shame in violent female offenders is poorly understood and there is limited research to date which has considered this particular and pertinent concept. It has been argued that qualitative methodologies are especially useful to investigate shame, due to the context dependent nature of this emotion (Hedderman, Gunby & Shelten, 2011; Retzinger, 1995). A grounded theory approach was utilised because this method of data collection and analysis is the most suitable for exploring unknown phenomenon with a need for further theoretical understanding. This methodology also provides clear guidelines that encourage flexibility and innovation to enhance understanding and offer novel theories and perspectives (Strauss & Corbin, 1998). A social constructionist version of grounded theory was utilised due to its epidemiological stance suggesting that categories and theories are constructed by the

researcher in response to their interactions with research participants and data (Charmaz, 2006).

Increasing the knowledge and understanding of shame and its role in violent female offending could potentially inform appropriate and effective interventions for female offenders, helping to reduce recidivism (Hollin & Palmer, 2006). Improving such interventions could have economic, social and personal benefits for female offenders, their families and the general population, affirming that this research is of interest and benefit to the wider public.

## **Method**

### **Design**

The current study utilised a qualitative design to investigate shame in violent female offenders. Semi-structured interviews were conducted using Charmaz's (2006) social constructivist version of grounded theory. This version of grounded theory enabled the researcher to acknowledge her role in creation of the data and the analytic discovery of ideas and concepts. Relevant factors that the researcher took into consideration throughout the process included; her role as a trainee clinical psychologist; prior experience of working therapeutically in both the community and inpatient settings; and her own personal life experiences.

### **Measures**

**Offending history.** Staff identified women suitable for participation that met the Historical Clinical Risk Management-20 (HCR-20 v3) definition of violence. Self-reported offending history was also collected from participants at the interview stage.

**Demographic information (Appendix C).** Demographic information was collected at the beginning of the interviews, using a structured questionnaire designed for the current study. The questionnaire investigated age, nationality, employment, education, relationship/marital status, offending history, child status (e.g. whether they had any children and if so, whether they were living with the participant or accommodated elsewhere), housing, financial support, substance misuse, mental health, trauma (e.g. experience of childhood and adulthood victimisation) and self-harm.

### **Participants and recruitment**

One-hundred and ninety-nine women offenders involved in Criminal Justice Services (CJS) across central Scotland were invited to participate in the study. Inclusion criteria were being female, over 18 years of age, and proficient in understanding and speaking English. Further, having a past history of the perpetration of interpersonal violence was required. The HCR-20 v3 definition of violence was used to inform appropriate recruitment:

Interpersonal violence, defined as actual, attempted, or threatened infliction of bodily harm on another person. Bodily harm includes both physical and serious psychological harm...psychological harm includes fear of physical injury, and other emotional, mental or cognitive consequences of the act in question.

(Douglas, Hart, Webster, & Belfrage, 2013, p. 36).

The exclusion criteria was acute experience of psychosis, learning disability and being intoxicated at the time of the interview. Recruitment took place between May 2016 and February 2017. Eight white Scottish women between the ages of 23 and 60 ( $M=35$ ,  $SD=13$ ) participated in the study. Five participants were on community payback

orders with supervision and the other 3 had completed their orders. The number of self-reported previous convictions ranged from 0-30 ( $M=10$ ,  $SD=10$ ). Breach of the Peace was the most commonly reported criminal conviction (reported by 5 participants), followed by assault (4 participants), drug related convictions (2 participants), breach of order (2 participants), theft (1 participant) and attempted murder (1 participant). Four participants had been incarcerated in the past ( $M=5$ ,  $SD=4$ ) and the longest time in custody ranged from 5 months to 3 years, 2 months. Five participants reported being single, one widowed, one married and one in a relationship. Six participants reported having children; two were over 18 and lived on their own, one lived at home and three with another family member, adopted or in foster care. One participant did not complete the experiences of childhood trauma section; however, all seven who did complete this section reported experiences of being physically, sexually or emotionally abused, witnessing another being abused, suffering neglect, parental substance misuse or mental health problems. Six participants reported experiencing multiple traumas and five of these included experiences of childhood sexual abuse. All seven participants who completed the adult victimisation section reported experiences of this (being physical, emotionally or sexually abused or witnessing abuse). All participants reported experiencing current mental health problems, seven reported taking medication, and six reported that they were receiving psychological treatment.

**Semi-structured interview schedule (Appendix B).** A semi-structured interview was conducted and prompts were designed to be open-ended to allow for the collection of rich data. The broad areas that were covered related to life experiences, offending, shame and violence e.g. “can you tell me about the first time you came into contact with the police?”. However, the interviews were designed to follow the verbal path of the participant, in keeping with the method of constructionist grounded theory (Charmaz,

2006). The interview started with a question aimed at engaging participants and ended by asking an open question inquiring if the researcher had missed anything important. This was conducted to ensure that any overlooked pathways were expanded upon and provided opportunity for the interview to finish on a more comfortable topic.

**Ethical considerations (Appendix I, J & K).** The current study was approved by the Scotland Research Ethics Committee and local NHS Research and Development Offices. Participation was voluntary; participants were informed that they could withdraw from the study at any time. Interviews were digitally recorded and then transcribed removing anything that might identify the participant or others known to them. The researcher worked closely with all services to ensure emotional support was available to participants throughout the study. The researcher was transparent about her dual role as a researcher and trainee clinical psychologist. It was made clear that treatment in the Criminal Justice Service would not be affected by engagement or non-engagement in the research.

**Procedure.** To widen the pool of appropriate participants, recruitment was conducted across five Criminal Justice Services, across which there were a total of 199 female offenders. The number of women who met the HCR-20 V3 definition was, however, unknown. Eligible participants were identified using information gathered via communication with key workers, case managers and psychologists. Study information was passed onto key workers, who identified and passed on information leaflets to women potentially interested in the study (see Appendix E & F). Potential participants were then given a minimum of two weeks for consent. Subsequently, staff members arranged an interview date/time that was most convenient for both parties.



Participants completed a consent and then background information form (see Appendix C & H) and were assured that all interview data would be anonymised.

### **Analysis**

Social constructionist grounded theory methods (Charmaz, 2006) were used to analyse the transcribed interviews using Dedoose software (<http://www.dedoose.com>). Reflective notes were written during and after the interview to capture further information (e.g. the researcher's own emotions or reflections). Transcripts were initially coded line-by-line and then organised into higher order categories (see Appendix G). These categories emerged through reflective memos and constant comparative analysis of the categories. The third transcript was cross-coded by a clinical psychologist and co-author to ensure internal validity. Iterative coding was used to ensure that the understandings were coming from the data, and categories were re-examined in line with the provisional model. Theoretical sufficiency was employed with the data; therefore recruitment ceased when sufficient categories had been suggested by the data to provide an adequate theoretical explanation (Dey, 1999).

### **Results**

Throughout the interviews, several theoretical categories emerged suggesting that childhood sexual abuse or neglect in the context of unavailable, uncompassionate and insecure relationships led to high levels of shame and unhelpful emotion regulation strategies including self-harm, substance misuse and violence. During the interviews threatened or physical violence against another was most commonly reported in the context of protecting the self from physical harm or abuse, in response to feelings of judgment from others and disbelief after disclosure of sexual abuse. Self-harm, substance

misuse and violence may have been used to protect the self from further abuse or to regulate negative emotions including shame (see Figure 1). However, the model identified that positive, secure and compassionate relationships could mediate the harmful impact of shame. In this context, women were able to regulate their emotions, including shame, using relationships rather than violence, substance misuse or self-harm.

Extracts taken from the interviews are included below to illustrate emergent categories. Pseudonyms are used throughout the extracts to preserve anonymity.

### **Childhood sexual, physical or emotional abuse and neglect**

A key category that emerged was the experience of childhood sexual, physical or emotional abuse and neglect. All participants described suffering either sexual, physical or emotional abuse by their parents or a first degree relative. Of these eight participants, five described experiencing childhood sexual abuse:

Carla: I didn't know a lot about it, like I didn't understand the abuse, but I knew it wasn't right. It was hard trying to tell your family, it was another kettle of fish. Especially when it was your family, and both sides of the family, and your brother's pals, and anybody else that wanted to do it. Ah...it was one of the worst, worst things, to happen. I wouldn't wish it, wouldn't wish it on anyone.

Another category that emerged was parental awareness of the abuse or being disbelieved after disclosure (*Carla: I'm telling you your daughters been abused that regular and you're not believing her*). These childhood experiences of severe and enduring sexual abuse coupled with parental awareness and/or denial of the abuse, appeared to be linked with the development of negative beliefs about the self, such as worthlessness (*Sue: I just didnae understand how any mother could do that eh. I really dunnae. It's just beyond me.... She made me feel worthless*) and about others as untrustworthy (*Patricia: so there was no trust*). Participants also linked these childhood experiences with shame.

Patricia: Um, I was abused as a kid and I felt it was all my fault, and a lot of shame round that, I thought it was my fault obviously. I felt shame, I couldn't talk to anybody because it was my father and I didn't want to tell anyone what my father had done to me so there was a lot of shame round that because it was a member of my own family.

### **Emergence of unhelpful coping strategies, including violence in the context of insecure unavailable/uncompassionate relationships**

Another category that emerged from the interviews was that participants felt that no one could either support them emotionally or protect them physically. This may represent an avoidant attachment style:

Particia: Erm ... really low but wanting somebody to, having nowhere to turn to. I felt as though nae body could help me, you know, erm, I was wanting somebody to help me.

Little or no emotional support in the context of early childhood physical, sexual or emotional abuse may have resulted in the belief that close relationships do not provide a source of comfort. Therefore, participants may have developed an avoidant attachment style, leading to difficulty utilising support from others in times of stress (*Clare: I'd said in prison that I didn't want anyone to know I was in there, including my family*). This may have led to emotion recognition and regulation difficulties and the deployment of harmful behaviours, such as self-harm, substance misuse and violence, to regulate difficult emotions including shame.

Jo: I was running around in circles, chaotic lifestyle and thinking that drink was a temporary answer and it was helping me forget. But I was also on anti-depressants so it would make me worse or it would make me angry coz I could nae ken how to show my emotions or what emotions to feel, so that used to be angry.

Participants also reported feelings of anger and the use of violence in adulthood as a response to situations where they felt disbelieved or judged. (*Patricia: When I was getting drunk after attacking a police in street because I seen them to blame*). These

situations may have elicited feelings of shame which were already heightened due to childhood victimisation.

Carla: Anger, the booze, I had a lot of anger in me because of the abuse. I just got to the stage when I couldn't even tell [my best friend] she just knew when I turned up all the time. I should have died at birth. It still hurts.

Therefore, it may be conceptualised that violence was used in these instances to protect the self from feelings of shame. This finding is in line with Gilligan (1996, 2000), who suggests that feelings of humiliation, ridicule or disrespect evoke violence as a mechanism to replace feelings of shame with pride and self-esteem. Furthermore, this is in line with the shame-rage theory presented by Lewis' (1971), suggesting that feelings of shame can lead to hostile anger or humiliated fury as a protection from the feelings of powerlessness and defensiveness elicited by shame. Anger could therefore be protective, because the blame is shifted to the other, relieving the individual from unbearable feelings of shame.

### **Positive, secure, compassionate relationships**

All but one participant talked about positive, secure, compassionate relationships, whereby the self was regarded as good by others and a realistic possibility of change, growth and repair was presented. When participants discussed difficult situations in which others showed compassion, they could frame their actions as bad rather than seeing the entire self as bad, leading to help seeking.

Patricia: Erm, and then they got me into the car, and they were actually quite nice. They were saying "Patricia, get help, you need to get help, you need to deal with your issues." And they were alright, you know. They knew I had issues, do you know what I mean? I wasn't doing it for nothing, I wouldn't, I'm not that type of person, but I was with the drink. But the police said, at that time, they were alright. You know, they were saying "you need to get yourself together". But, you know, they were alright that last time, they were definitely alright. But that's when I got the help.

When participants discussed recovery and change, the catalyst seemed to be secure, positive and compassionate relationships.

Jo: What made me change was um, being given an opportunity to change my life and for somebody to say to me, “I am a good person, I am loved”. Just because I have mental health problems doesn’t mean that I’m on the scrap heap kind of thing and we all go through tough times and that, but people can pull through and people can change and want to change.... I seen what my life was like, I was, I didn’t want life like that. I wanted to make my kids proud.

The development of these new relationships may have led to new more positive beliefs about the self.

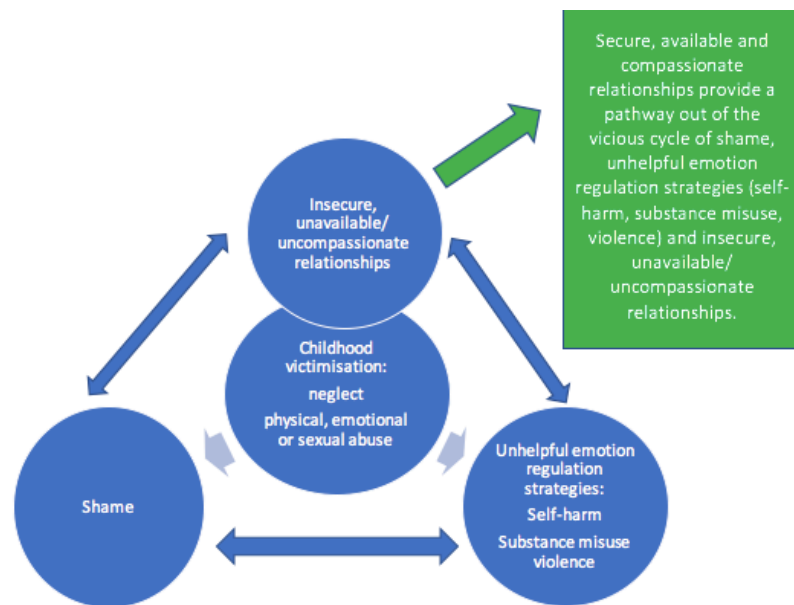
### **Learning how to respond to shame without violence – the importance of positive relationships**

All but one participant reported that building new positive relationships had been helpful for moving forward. Some participants discussed relationships with staff in services, whilst others talked about strengthening family relationships or having a child. In response to these new positive relationships participants reported being able to sit through feelings of judgment or shame (Mary: *I felt like a terrible person and I felt like a terrible mother... and I thought do you know what, I’m not even going to care that you’re sitting there, I’ve got my son, that’s all that matters*). Some participants also discussed how positive relationships established within services had led to more helpful strategies in response to negative emotions including anger.

Sue: Normally I would have battered her, that’s what I normally would have done, I would have knocked her out but I never ... I was so proud of myself ..... And my brother says that too “I’m so proud of you”... I feel [the service] has been such a positive place and um so yeah. If I went away now and battered somebody I’d feel like turning back to [the service] on Monday and be like, oh God, and tell everybody I’ve done that and I’d rather not.

### **Childhood victimisation, shame, insecure unavailable/uncompassionate relationships and unhelpful emotion regulation strategies, including violence**

Figure 1 presents a provisional model of the hypothesised relationship between childhood victimisation, shame, insecure, uncompassionate/unavailable relationships and violence in some women.



*Figure 1: Hypothesised model of childhood victimisation, shame, insecure unavailable/uncompassionate relationships and unhelpful emotion regulation strategies, including violence.*

All participants reported the experience of childhood neglect or physical, emotional or sexual abuse; a large proportion of these women reported that other people could not protect them physically or support them emotionally, which may have led to an avoidant attachment style. For some participants, this initial victimisation experience was coupled with a secondary experience of trauma and a sense of invalidation due to parental involvement with childhood abuse (*Patricia: I didn't want to tell anyone what my father had done to me*), parental disbelief after disclosure (*Carla: I think the thing that really hurts me, was that she never believed me, she used to just call me a liar*) or parental collusion with the abuse (*Sarah: She let it happen three times to me, er, not three times, more than three times but with three different people. And erm, she like basically just told me to keep shhh*).

Childhood abuse in the context of invalidating parenting may have led to feelings

of shame, worthlessness and beliefs that the self is unwanted or unlovable (*Patricia: I thought it was my fault obviously. I felt shame*). Due to these experiences of invalidation some participants may have developed internal, stable and global attributions about the abuse (*Patricia: I thought there was something wrong with me*). This attribution style has been linked with higher levels of internalised shame (Lewis, 1992) and may have caused difficulties developing capacity for self-love and self-empathy (Gilligan, 2003).

Participants therefore may have learned to cope with painful emotions including shame using unhelpful coping strategies (see Feiring et al., 1996) such as self-harm and substance misuse (*Jo: I was running around in circles, chaotic lifestyle and thinking that drink was a temporary answer and it was helping me forget*).

It seems that violence may have also been used as a coping strategy to deal with painful emotions including shame which were triggered by experiences of invalidation or disbelief (*Carla: and he said, you're a cheeky little bastard you asked for it, and I'm like is that right? I'll fucking show you what a lassie can do*). Participants were unable to regulate intense emotional states including anger, due to an absence of secure, emotionally available and compassionate relationships and a lack of helpful emotion regulation and self-soothing strategies.

Clare: my gran actually took my phone off me, she took all my communication stuff off me, so I couldn't actually contact anyone. So, I ended up, it all started up again, and that was when I set the fire, and that's when I got started coming back in contact with the police.

In some cases, participants used violence as a defence against shame by projecting these feelings onto the actual or perceived shaming other.

Sarah: Well when I'm angry I get a big rage ... I just start to hate everybody eh. I do, I just start to see people's faults, erm ...aye I look at people and no like I judge them or anything, it's just that I always think folk are looking at me and judging me. Even folk that do not know me, like I could walk by a stranger and think to myself that they are looking at me and thinking stuff about me and erm things like that and erm sometimes it can just build up erm and it just explodes.

Some participants may be attempting to ward off feelings of shame and inadequacy by replacing this with a sense of self-worth and self-esteem in the context of insecure attachment (Gilligan, 2003). It appears that the vicious cycle of shame and violence may therefore be fuelled by uncompassionate or abusive relationships. These types of relationship may increase shame whilst blocking an individual's ability to reduce shame through social connection (Feiring et al., 1996). This may therefore lead to unhelpful emotion regulation strategies such as violence, self-harm and substance misuse in response to shame; however, these strategies increase levels of shame in the long term, further perpetuating this destructive cycle (see Figure 1).

Although insecure, unavailable and uncompassionate relationships appeared to fuel the vicious cycle of shame and violence, it appeared that secure, compassionate, available relationships could break this same cycle. Some participants discussed how compassionate responses from friends, services or the police, led them to seek help (Patricia: *You know, they were saying you need to get yourself together. But, you know, they were alright that last time, they were definitely alright. But that's when I got the help*). This finding is consistent with the constructionist view of shame (Leach & Cidam, 2015) suggesting that shame is not always a negative emotion associated with avoidance, but can be helpful when one's failure or social image is repairable.

Jo: I went through years of being unable to say anything to people you know, young people's services and being in hospital, being out of hospital, seeing psychologists, doing therapy, nothing was like really working for me, erm, until I came here.

Researcher: What do you think was different about here, to all the things that you had before?

Jo: They believed in me, took a chance on me.

All participants, apart from one, talked about building new positive, secure and compassionate relationships (Sarah: *they've managed to help me stop drinking and that,*



*they're kinda like a backbone for me. I've got problems and I phone them up, I can talk about it).* The development of these relationships may have provided participants with a new, more helpful way to regulate difficult emotions including shame, breaking the symbiotic relationship between shame and violence (see Figure 1).

## **Discussion**

This social constructionist grounded theory study aimed to explicitly investigate shame in violent female offenders. The current study may therefore suggest that violence is the result of early victimisation experiences in the context of insecure, unavailable and uncompassionate relationships. Findings suggested that some women may have used physical or threatened violence as a way to protect the self from physical harm or abuse, feelings of perceived judgment, or from disbelief after disclosure of sexual abuse. Therefore, the current findings may be specific to this particular population of women. This relationship is likely to be complex and may involve multiple mediating factors not discussed within the scope of this study; however, the current model may provide initial insights into some of the relevant factors implicated in this relationship. The results are consistent with previous research demonstrating high levels of current and past victimisation in female offenders (Carlson & Shafer, 2010; Gelsthorpe et al., 2007). All participants in the current study reported childhood victimisation such as neglect, physical, sexual or emotional abuse. Furthermore, many participants discussed childhood sexual abuse and the experience of disbelief and invalidation by others after disclosure. Some participants reported that these experiences led to feelings of shame, and therefore these traumatic early experiences may be related to higher levels of shame in adulthood. This is consistent with literature indicating the high prevalence of interpersonal violence and abuse histories in female offenders (e.g. Carlson & Shafer,

2010; Gelsthorpe et al., 2007; Lynch et al., 2013; DeHart et al., 2014; Messina & Grella, 2006; Zlotnick et al., 2008) leading to experiences of internalised shame (Feiring et al., 1996).

The current model suggests that early victimisation without available compassionate relationships may lead to an insecure avoidant attachment style, high levels of internalised shame and unhelpful emotion regulation strategies including violence. This is consistent with findings demonstrating that the experience of childhood trauma increases the likelihood of an insecure attachment style (Cassidy & Shaver, 1999; Styron & Janoff-Bulman, 1997), impacting on an individual's ability to deal with stress later in life (Finkelhor, Ormrod, & Turner, 2009). Individuals may experience difficulties with healthy expression of emotions due to limited ability to utilise close relationships to regulate emotions. This finding is consistent with a model by Feiring et al., (1996) suggesting that sexual abuse leads to higher levels of shame in the absence of appropriate social support. The model suggests that in the absence of social support, victims of sexual abuse will not feel loved, valued and part of a reliable, trusted social network. Therefore, they are more likely to hold negative internal, global, stable attributions about the cause of the abuse, leading to higher levels of shame and poorer adjustment. Feiring et al., (1996) suggest that poorer adjustment may include depression and dissociative disorder and that dissociation is used as a defence against the negative feelings of shame. The current model also suggests that some women may attempt to regulate negative feelings of shame in unhelpful ways, but additionally proposes that mechanisms including self-harm, substance misuse and violence are used.

The current model suggests that in the absence of secure, supportive and compassionate relationships, participants attempted to regulate negative emotions including shame linked with past victimisation experiences through substance misuse, self-harm or violence. These findings are in line with literature demonstrating that

substance misuse and self-harm can be used as an attempt to regulate negative emotions including shame (e.g., Kreis et al., 2016; Milligan & Andrews, 2005).

The findings are also consistent with studies demonstrating that anger is one of the most persistent consequences of childhood sexual abuse (Scott & Day, 1996), and with studies linking a propensity for shame with anger and hostility (Andrews et al., 2000; Bennett, et al., 2005; Harper & Arias 2004; Paulhus et al., 2004; Tangney & Dearing 2002; Tangney et al., 2011; Velotti, Elison & Garofalo, 2014). However, the link between shame, violence and insecure attachment is less well documented and could be conceptualised using Tomkin's (1963) work and Gilbert's (2003) evolutionary model of shame. These conceptualisations suggest that shame proneness is a trait that emerges from attachments with primary caregivers in early life. These early relationships will determine views about self and emotion regulation strategies. When an individual has experienced childhood trauma, such as severe sexual abuse, they may develop beliefs about themselves as being shameful. These internalised beliefs may be elicited by a threat to social status, leading to either acceptance of lowered status through submission and avoidance, behaviours which increase social attractiveness, or through strategies that are aimed at signalling power, such as anger and aggression (Gilbert, 1997). The strategy adopted will, however, depend on prior learning experiences, situational factors or physiological states (Gilbert, 2002). Therefore, in the absence of secure relationships (that could be utilised to increase social attractiveness) behaviours such as aggression and violence may be used to cope with shame. This is in line with Gilligan (2003), who suggests that violence is used as an attempt to replace shame with self-esteem. Therefore, it may be that situations evoking painful feelings of shame (e.g. feeling disbelieved about past victimisation) may lead to unhelpful emotion regulation strategies such as self-harm, substance misuse and violence as an attempt to self-regulate.

An interesting finding that emerged from the current study is the reversal of the above process. Participants spoke about secure, available and compassionate relationships and saw this as a key reason for positive change and recovery. These participants linked their past negative experiences to situations rather than blaming negative, stable, global self-attributions of the self. Therefore, secure, positive and compassionate relationships may have led to the development of positive beliefs about the self. This may have reduced internalised shame in some violent female offenders through discussion of perceived shameful events and re-working of their negative internal beliefs. Therefore, in situations that elicit feelings of shame and anger, newly developed positive self-beliefs (e.g. feeling worthy or lovable) may prevent the utilisation of unhelpful regulation strategies including violence, potentially breaking the cycle between shame and violence.

One possible way to understand the positive change reported by participants is using the concept of reparenting (Young, Klosko & Weishaar, 2003). Reparenting suggests that when core needs, which were missed in early childhood (e.g. warmth, empathy, validation and recognition), are met later in life, the individual will be able to develop a secure attachment. This can have a positive impact on maladaptive schemas and modes which lead to increased adaptive functioning (for a review see Young, Klosko & Weishaar, 2003). The positive change discussed by participants could be understood through the development of new long term relationships with staff, family or friends. This may have provided participants with a consistent secure relationship. Although Young et al., (2003) are specifically referring to the therapeutic relationship, it is possible that this same concept also applies to staff in services and available friends or family members. New relationships that provide this secure attachment may have led to re-construction of negative beliefs about the self and others, leading to the use of more helpful emotion regulation strategies. However, future research specifically focusing on mechanisms of

change in female offenders would be required to further our understanding of this phenomenon.

### **Strengths and limitations**

Limitations of the current study should be considered. A social constructionist grounded theory method was utilised and therefore the results of this study are influenced by the views and experiences of the researchers. Another important consideration is recruitment bias. A large proportion of potential participants were unstable, unable or unwilling to participate in the study. Therefore, it is likely that the women who took part in this study represented a sample of violent female offenders who had benefitted from services and treatments offered, and broad generalisations cannot be made across all female offender populations.

Although the findings are based on a small sample of eight violent female offenders, findings suggest several important theoretical and clinical implications. As noted in the literature (e.g., Blanchette & Brown, 2006; Kreis et al., 2016) there is limited research investigating the specific needs of female offenders. There is even less research specifically assessing life histories of violent female offenders. The current study therefore provides vital information about the extensive trauma experienced by some female offenders and how their trauma experiences may be complexly related to their risk of violence. This could have implications for violence risk assessment and management. The study also provides insight into the importance of providing secure, available, consistent and compassionate relationships within criminal justice community services to promote wellbeing, recovery and desistance from violent offending. One possibility is that these types of relationship may be the key ingredient promoting recovery within a therapeutic milieu. However, future research studies using quantitative methodologies

would be required to investigate and quantify mechanisms of change within these settings.

## References

- Andrews, B, Brewin, C.R, Rose, S., Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: the role of shame, anger, and childhood abuse. *Journal of Abnormal Psychology*, 109, 69–73. doi:org/10.1037/0021-843X.109.1.69
- Andrews, D. A., Bonta, J., & Wormith, S. J. (2006). The recent past and near future of risk/need assessment. *Crime & Delinquency*, 52, 7-27.  
doi:10.1177/0011128705281756
- Bartlett, A., Jhanji, E., White, S., Anne Harty, M., Scammell, J., & Allen, S. (2015). Interventions with women offenders: a systematic review and meta-analysis of mental health gain. *The Journal of Forensic Psychiatry & Psychology*, 26(2), 133-165.
- Bennett, D. S., Sullivan, M.W., Lewis, M. (2005). Young children's adjustment as a function of maltreatment, shame, and anger. *Child Maltreatment*, 10 (4), 311–323. doi: 10.1177/1077559505278619
- Bennett, D. S., Sullivan, M. W., & Lewis, M. (2010). Neglected children, shame-proneness, and depressive symptoms. *Child maltreatment*, 15(4), 305-314.
- Bernstein, D. P., Arntz, A., & Vos, M. D. (2007). Schema focused therapy in forensic settings: Theoretical model and recommendations for best clinical practice. *International Journal of Forensic Mental Health*, 6(2), 169-183.
- Bernstein, D. P., Nijman, H. L., Karos, K., Keulen-de Vos, M., de Vogel, V., & Lucker, T. P. (2012). Schema therapy for forensic patients with personality disorders: Design and preliminary findings of a multicenter randomized clinical trial in the Netherlands. *International Journal of Forensic Mental Health*, 11(4), 312-324.
- Blanchette, K. & Brown, S. L. (2006). *The assessment and treatment of women offenders: An integrative perspective*. Chichester: John Wiley & Sons.

- Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. London: Hogarth Press and the Institute of Psychoanalysis:
- Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation, anxiety, and anger*. London, UK: Hogarth Press and the Institute of Psychoanalysis.
- Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss*. Basic Books: New York.
- Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview.
- Buss, A. H., & Perry, M. (1992). The aggression Questionnaire. *Journal of Personality and Social Psychology*, 63, 452-459.
- Carlson, B.E., & Shafer, M.S. (2010). Traumatic histories and stressful life events of incarcerated parents I: Childhood and adult traumatic histories. *The Prison Journal*, 90, 475–493.
- Cassidy, J. (1999). *Handbook of attachment: Theory, research, and clinical applications*. Guildford Press: New York.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.
- Cicchetti, D., Toth, S. L., & Lynch, M. (1995). Bowlby's dream comes full circle: The application of attachment theory to risk and psychopathology. *Advances in Clinical Child Psychology*, 17, 1–75.
- Commission on Women Offenders (2012). *Final report 2012*. Edinburgh: Scottish Government. Retrieved 31 March 2013 from <http://www.scotland.gov.uk/About/Review/commissiononwomenoffenders/finalreport-2012>.
- Coie, J.D., & Dodge, K.A. (1998). Aggression and antisocial behavior. In W. Damon & N.Eisenberg (Eds.), *Handbook of child psychology: Social, emotional, and personality development*, Vol. 3 (5<sup>th</sup> ed., pp. 779-862). New York: Wiley.



- Corston, J. (2007). *The Corston report*. London: Home Office. Retrieved 31 March 2013 from <http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf>
- Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training*, 41, 412-425.
- Covington, S.S., & Bloom, B., E. (2006). Gender Responsive Treatment and Services in Correctional Settings. *Women and Therapy*, 29, (3-4) 9-33. doi:10.1300/J015v29n03\_02
- Dedoose Version 7.0.23, web application for managing, analyzing, and presenting qualitative and mixed method research data (2017). Los Angeles, CA: SocioCultural Research Consultants, LLC ([www.dedoose.com](http://www.dedoose.com)).
- DeHart, D., Lynch, S., Belknap, J., Dass-Brailsford, P., & Green, B. (2014). Life history models of female offending: The roles of serious mental illness and trauma in women's pathways to jail. *Psychology of Women Quarterly*, 38, 138-151. doi: 10.1177/0361684313494357
- De Vogel, V., Stam, J., Bouman, Y. H., Ter Horst, P., & Lancel, M. (2016). Violent women: A multicentre study into gender differences in forensic psychiatric patients. *The Journal of Forensic Psychiatry & Psychology*, 27(2), 145-168.
- Dey, I. (1999). *Grounding Grounded Theory Guidelines for Qualitative Inquiry*. San Diego: Academic Press.
- Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). HCR-20 Version 3: Assessing Risk for Violence. User guide. Vancouver, BC: Mental Health Law, and Policy Institute, Simon Fraser University.
- Elison, J. (2005). Shame and guilt: A hundred years of apples and oranges. *New Ideas in Psychology*, 23(1), 5-32.
- Fazel, S., Bains, P., & Doll, H. (2006). Substance abuse and dependence in prisoners: a systematic review. *Addiction*, 101, 181-191.

- Fazel, S., Seewald, K. (2012). Severe mental illness in 33,588 prisoners worldwide: systematic review and meta-regression analysis. *The British Journal of Psychiatry: the Journal of Mental Science*, 200 (5), 364-373. doi: 10.1192/bjp.bp.111.096370
- Feiring, C., Taska, L., & Lewis, M. (1996). A process model for understanding adaptation to sexual abuse: The role of shame in defining stigmatization. *Child abuse & neglect*, 20(8), 767-782.
- Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2009). Lifetime assessment of poly-victimization in a national sample of children and youth. *Child abuse & neglect*, 33(7), 403-411.
- Friedrich, W. N. (2002). *Psychological assessment of sexually abused children and their families*. Sage.
- Gelsthorpe, L., Sharpe, G., & Roberts, J. (2007). *Provision for Women Offenders in the Community*. London: Fawcett Society.
- Gilbert, P. (2002). Evolutionary approaches to psychopathology and cognitive therapy. *Journal of Cognitive Psychotherapy*, 16(3), 263-294.
- Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology*, 70, 113-147.
- Gilbert, P. (1998). What is shame? Some core issues and controversies. In *Shame: Interpersonal behaviour, psychopathology and culture* (pp. 3–36). New York, NY: Oxford University Press.
- Gilbert, P., & Andrews, B. (1998). *Shame: Interpersonal behavior, psychopathology, and culture*. Oxford University Press on Demand.
- Gilbert, P., Pehl, J. & Allan, S. (1994) The phenomenology of shame and guilt: An empirical investigation. *British Journal of Medical Psychology*, 67, 23-36.
- Gilfus, M. E. (1993). From victims to survivors to offenders: Women's routes of entry and immersion into street crime. *Women & Criminal Justice*, 4(1), 63-89.

- Gilligan, J. (2003). Shame, guilt, and violence. *Social Research*, 1149-1180.
- Guest, G., Bunce, A. & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18, 59–82.
- Hannah-Moffat, K. (2005) Criminogenic needs and the transformative risk subject Hybridizations of risk/need in penalty. *Punishment & Society*, 7 (1), 29-51. doi: 10.1177/1462474505048132
- Harper, F.W.K., Arias, I. (2004). The role of shame in predicting adult anger and depressive symptoms among victims of child psychological maltreatment. *Journal of Family Violence*, 19 (6), 367–375. doi: 10.1007/s10896-004-0681-x
- Hassan, L., Frisher, M., Senior, J., Tully, M., Webb, R., While, D., & Shaw, J. (2014). A cross-sectional prevalence survey of psychotropic medication prescribing patterns in prisons in England.
- Hedderman, C., Gunby, C. & Shelton, N. (2011). What women want: The importance of qualitative approaches in evaluating work with women offenders. *Criminology and Criminal Justice*, 11, 3-19.
- Hollin, C. R. & Palmer, E. J. (2006). Criminogenic need and women offenders: A critique of the literature. *Legal and Criminological Psychology*, 11, 179-195.
- Hosser, D., Windzio, M., & Greve, W. (2008). Guilt and shame as predictors of recidivism. *Criminal Justice and Behavior*, 35, 138-152.
- Howells, K. (2004). Anger and its link to Violent Offending. *Journal of Psychiatry, Psychology and Law*, 11 (2), 189-196. doi:10.1375/pplt.2004.11.2.189
- HM Inspectorate of Prisons (2007). HMP and YOI Cornton Vale, 19-20.
- Kaufman, G. (1989) *The Psychology of Shame: Theory and Treatment of Shame-Based Syndromes*. New York: Springer.
- Kreis, M. K., Gillings, K., Svanberg, J., & Schwannauer, M. (2016). Relational Pathways to Substance Misuse and Drug-Related Offending in Women: The Role of

- Trauma, Insecure Attachment, and Shame. *International Journal of Forensic Mental Health*, 15(1), 35-47.
- Lawlor, E., Nicholls, J., & Sanfilippo, L. (2008). *Unlocking Value: How we all benefit from investing in alternatives to prison for women offenders*. new economics foundation.
- Leach, C. W., & Cidam, A. (2015). When is shame linked to constructive approach orientation? A meta-analysis. *Journal of Personality and Social Psychology*, 109 (6), 983-1002.
- Lewis, H.B. (1971) *Guilt and Shame in Neurosis*. NY: International Universities Press.
- Lewis, H.B. (1986) The role of shame in depression. In M. Rutter, C.E. Izard & P.B. Read (Eds.) *Depression in Young People: Developmental and Clinical Perspectives*. NY: Guilford Press.
- Light, M., Grant, E., & Hopkins, K. (2013). *Gender differences in substance misuse and mental health amongst prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners*. London: Ministry of Justice.
- Lynch, S. M., DeHart, D. D., Belknap, J., & Green, B. (2013). Women's pathways to jail: Examining mental health, trauma, and substance use. *NCJ*, 241045.
- McClellan, C. S., Farabee, D., & Crouch, B. M. (1997). Early victimization, drug use, and criminality: A comparison of male and female prisoners. *Criminal Justice and Behavior*, 24, 455-476. doi: 10.1177/0093854897024004004
- Messina, N., & Grella, C. (2006). Childhood trauma and women's health outcomes: A California prison population. *The American Journal of Public Health*, 96(10), 1842-1848.

- O'Brien, M., Mortimer, L., Singleton, N., & Meltzer, H. (2001). *Psychiatric morbidity among women prisoners in England and Wales*. London: Office for National Statistics.
- Parke, R.D., & Slaby, R. G. (1983). The development of aggression. In P. Mussen & M. Hetherington (Eds.), *Handbook of child psychology: Socialization, personality and social development*, Vol. 4 (4<sup>th</sup> ed., pp. 547-641). New York: Wiley.
- Paulhus, D. L., Robins, R. W., Trzesniewski, K.H., & Tracy, J.L. (2004) Two replicable suppressor situations in personality research. *Multivariate Behavioral Research*, 39, 303–328. doi:org/10.1207/s15327906mbr3902\_7
- Pinto-Gouveia, J., & Matos, M. (2011). Can shame memories become a key to identity? The centrality of shame memories predicts psychopathology. *Applied Cognitive Psychology*, 25, 281–290. doi:10.1002/acp.1689
- Retzinger, S.M. (1995) Identifying shame and anger in discourse. *American Behavioral Scientist*, 38, 8, 1104-1113
- Scottish Government (2008). *Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons*. Edinburgh: Scottish Government.
- Scottish Government (2011). *Statistical Release Crime and Justice Series: Scottish prison population projections: 2010-11 to 2019-20*. Edinburgh: Scottish Government.
- Scottish Government. (2015). New plans for women in custody announced. Retrieved from <https://news.gov.scot/news/new-plans-for-women-in-custody-announced>
- Singleton, N., Meltzer, H., Gatward, R., Coid, J. & Deasy, D. (1998). *Psychiatric morbidity among prisoners: summary report*. London: Office for National Statistics.

- Sorbello, L., Eccleston, L., Ward, T., & Jones, R. (2002). Treatment needs of female offenders: a review. *Australian Psychologist*, 37, 3, 198-205. doi:10.1080/00050060210001706876
- Stearns, P. (1995) Emotion. In R. Harre & P. Stearns (Eds.) *Discursive Psychology in Practice*. London: Sage.
- Straus, A., & Corbin, J. (1998). Basics of qualitative research: Techniques and procedures for developing grounded theory.
- Stuewig, J., & McCloskey, L. A. (2005). The relation of child maltreatment to shame and guilt among adolescents: Psychological routes to depression and delinquency. *Child Maltreatment*, 10(4), 324-336.
- Styron, T., & Janoff-Bulman, R. (1997). Childhood attachment and abuse: Long-term effects on adult attachment, depression, and conflict resolution. *Child abuse & neglect*, 21(10), 1015-1023.
- Tangney, J.P. (1992) Situational determinants of shame and guilt in young adulthood. *Personality and Social Psychological Bulletin*, 18, 2, 199-206.
- Tangney, J.P., & Dearing, R. (2002). Shame and Guilt. New York: Guilford.
- Tangney, J. P., & Fischer, K. W. (Eds.). (1995). Self-conscious emotions: The psychology of shame, guilt, embarrassment and pride. New York, NY: Guilford Press.
- Tangney, J.P., Miller, R.S., Flicker, L., & Barlow, D.H. (1996) Are shame, guilt and embarrassment distinct emotions? *Journal of Pers.and Social Psychology*, 70, 6, 1256-1269.
- Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual Review. Psychol.*, 58, 345-372.
- Tangney, J.P., Wagner, P. & Gramzow, R. (1992) Proneness to shame, proneness to guilt, and psychopathology. *Journal of Abnormal Psychology*, 101, 3, 469-478.

- Tangney, J. P., Stuewig, J., & Hafez, L. (2011). Shame, guilt, and remorse: Implications for offender populations. *Journal of Forensic Psychiatry & Psychology*, 22(5), 706-723.
- Tangney, J. P., Stuewig, J., & Martinez, A.G. (2007). Moral Emotions and Moral Behaviour. *Annual Review of Psychology*, 58, 345–372. doi:10.1146/annurev.psych.56.091103.070145
- Tangney, J. P., Stuewig, J., & Martinez, A.G. (2014). Two Faces of Shame: The Roles of Shame and Guilt in Predicting Recidivism. *Psychological Science*, 25, 3, 799-805. doi: 10.1177/0956797613508790
- Tedeschi, J., & Felson, R. B. (1994). Violence, aggression, and coercive actions. Washington, DC, US: American Psychological Association. doi: org/10.1037/10160-000
- Tilghman-Osborne, C., Cole, D. A., & Felton, J. W. (2010). Definition and measurement of guilt: Implications for clinical research and practice. *Clinical Psychology Review*, 30, 5, 536-546. doi:10.1016/j.cpr.2010.03.007
- Tompkins, S. S. (1963). *Affect, imagery, consciousness: II. The Negative Affects*. New York: Springer publishing company.
- Velotti, P., Elison, J., & Garofalo, C. (2014). Shame and aggression: Different trajectories and implications. *Aggression and Violent Behavior*, 19(4), 454-461.
- Walmsley, R. (2015). World female imprisonment list (Women and girls in penal institutions, including pre-trial detainees/remand prisoners). *World female imprisonment list (Women and girls in penal institutions, including pre-trial detainees/remand prisoners)*.
- Winham, K. M., Engstrom, M., Golder, S., Renn, T., Higgins, G. E., & Logan, T. K. (2015). Childhood victimization, attachment, psychological distress, and

substance use among women on probation and parole. *American Journal of Orthopsychiatry*, 85(2), 145.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. Guilford Press.

Zlotnick, C., Clarke, J. G., Friedmann, P. D., Roberts, M. B., Sacks, S., & Melnick, G. (2008). Gender differences in comorbid disorders among offenders in prison substance abuse treatment programs. *Behavioral sciences & the law*, 26(4), 403.



## Appendix A: Guidance for publication in The International Journal of Forensic Mental Health

The International Journal of Forensic Mental Health publishes original scholarship related to law and mental health. The journal is international and interdisciplinary, and values original research submissions, both quantitative and qualitative in nature, as well as literature reviews, case studies and theoretical articles. There is no maximum page limit or word count, but manuscripts should conform to the style requirements outlined in the Publication Manual of the American Psychological Association (currently in its 7th edition). The style requirements for this journal are provided below.

**Manuscript Submission.** *International Journal of Forensic Mental Health* receives all manuscript submissions electronically via the ScholarOne Manuscripts website (<http://mc.manuscriptcentral.com/UFMH>). ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, as well as facilitating the review process and internal communication between authors, editors and reviewers via a web-based platform. For ScholarOne Manuscripts technical support, you may contact them by e-mail or phone support via <http://scholarone.com/services/support/>. If you have any other requests please contact the editor of the journal, Dr. Barry Rosenfeld ([rosenfeld@fordham.edu](mailto:rosenfeld@fordham.edu)). Additional information on the ScholarOne system is available in the [guide for ScholarOne authors](#).

Please note that the *International Journal of Forensic Mental Health* uses [CrossCheck™](#) software to screen papers for unoriginal material. By submitting your paper to the *International Journal of Forensic Mental Health* you are agreeing to any necessary originality checks your paper may have to undergo during the peer review and production processes.

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. As an author, you are required to secure permissions if you want to reproduce any figure, table, or extract from the text of another source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source). All accepted manuscripts, artwork, and photographs become the property of the publisher.

**Recommending Reviewers.** The manuscript portal will request the names of potential reviewers. These should be individuals who you believe are qualified and appropriate to review the manuscript in an objective and informed manner. They should not be friends or collaborators, who are likely to be aware of your work and/or identity, and unable to objectively judge the submission. Typically these will be individuals that have published on the topic (e.g., authors that have been cited in the Introduction to your paper). You need not obtain permission from potential reviewers in advance. They will simply be added to our list of potential reviewers; they may or may not be contacted by the Editor/Associate Editor that processes your manuscript. If there are potential reviewers that you believe will not judge your work objectively, these individuals can also be identified during the submission process (i.e., as "non-preferred reviewers").

**Preparing Your Manuscript.** The *International Journal of Forensic Mental Health* requires that all manuscripts be prepared in accordance with the APA Publication Manual, 6th edition. All parts of the manuscript should be typed, double spaced, in 12-point font, and with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Manuscripts should be prepared for blind review, with a separate title page uploaded separately.

**Title Page:** The title page (which is not sent to reviewers, to preserve blind peer review) should contain only the title (preferably no more than 12 words), the author(s) names and the institutional affiliation for each author. Author credentials (e.g., degrees), mailing addresses, or acknowledgements should NOT be included on the title page. In addition, the title page should include a “Running Head” that will accompany the manuscript once typeset. The Running Head should not exceed 3-4 words.

**Abstract:** Each manuscript must include an Abstract (on a separate page) summarizing the content and key findings. Abstracts are NOT structured (i.e., are comprised of a single paragraph, without subheadings), and should not exceed 250 words. Avoid abbreviations, diagrams, and references. Some specificity regarding the study findings is also useful (e.g., some, but limited data rather than simply a statement that “significant associations were found between”).

The Abstract page should include 4-5 keywords indicating the primary focus of the manuscript (to facilitate search engines). Keywords should not be overly narrow or specific, but should provide sufficient information to enable search engines to identify the paper.

### **Manuscript Body:**

**Headings.** The heading structure for all sections follows the same top-down progression, regardless of how many subsections are contained within any section. See below for an example of the indentation, font, and punctuation that should be associated with each level of heading.

## **Introduction Approaches to Violence Risk Assessment**

Subheadings are NOT required in the Introduction, but when used, they must conform to the APA standards.

### **Method**

The number and depth of subheadings within the Method section will depend on length and complexity. Many Method sections will simply include a description of the participants and setting where they were drawn, along with a summary of the sample characteristics – with no subheadings needed. For longer sections, consider using subheadings (and even sub- subheadings) to clarify the text. Most Method sections will include, at a minimum, subheadings for Participants, Procedure, and Statistical Analysis

#### **Participants**

Note that this level of subheading should use “title case”, where most words are capitalized. The text for this level of subheading should be indented, below the subheading. All

paragraphs in the manuscript should be indented, with no spaces between paragraphs. **Sample characteristics.** Note that this level of subheading (if used) should only capitalize the first word. The text for this level of subheading begins on the same line.

## **Measures**

Note that many studies will not need a separate subheading for measures, but rather will include this information in the Procedure section.

**Instruments used to assess violence risk.** Some studies will be sufficiently complex such that subheadings for predictors and outcome variables are useful.

## **Procedure**

This section **MUST** include information about ethics approval for the study (assuming the paper describes a research study for which ethics approval is appropriate).

## **Statistical Analysis Plan**

A brief summary of the statistical analyses, and how they will address the study questions and variables, is useful in helping guide the reader through the Results that will follow.

## **Results**

Note that subheadings within the Results (and Discussion) will depend on content. See the paragraph below about formatting statistics.

## **Discussion**

The Discussion section should discuss the study findings, not simply repeat them. What are the implications, how much we understand contradictory or counterintuitive findings?

## **Limitations**

A discussion of study limitations – not simply a sentence listing them, is essential to interpreting the data from virtually every published study.

## **Conclusions**

**Reporting Statistics.** All statistics should be reported in accordance with APA style. In general, this means italicizing the actual statistic ( $F$ ), including the d.f., and giving exact  $p$  values ( $p = .03$ , not  $p < .05$ ). A  $p$  value below .001 should be reported as  $p < .001$ , not  $p = .00$ . Most statistics should include 2 decimal places, but in some cases one may be sufficient (e.g., percentages, means, etc). Three decimal places should be limited to situations where small gradations are meaningful (e.g.,  $p = .002$ , or for describing fit statistics for multivariate models, where small differences are relevant). Whenever possible, effect size estimates and 95% confidence intervals should be provided. Statistics that are presented in a table need not be repeated extensively in the text, unless there is a logical reason to do so (e.g., to highlight key findings, or identify the handful of significant findings from a larger pool of analyses).

However, you should refer to the table in the text and emphasize particular data in your narrative that may help the reader to interpret your findings. Examples of how to report inferential statistics in the body of your manuscript are provided below.

## □ Correlations

To test the hypothesis that positive associations would exist between psychopathy and violence risk, Pearson correlation analyses were performed and can be found in Table 1. Contrary to predictions, although PCL-R Factor 1 was significantly related to violence risk ( $r = .37, p < .01$ ), PCL-R Factor 2 was not ( $r$

$= .10, p = .29$ ).

### • ANOVA

Mean PCL-R scores differed significantly across risk categories,  $F[5, 38] = 4.01, p = .01$ .

Significant differences between risk categories were revealed in pair-wise comparisons.

Participants with low risk ratings had significantly lower psychopathy scores ( $M = 5, SD = 1.2$ ) than those with moderate risk ratings ( $M = 10, SD = 3.3$ ) and those with high risk ratings ( $M = 24, SD = 4.1$ ).

- Regression: When entered into a regression, age, number of prior arrests, and number of prior hospitalizations predicted violence risk rating  $F[3,44] = 2.36, p = .02$ , accounting for 27.3% of the citations and the reference list should be prepared in accordance with the APA Publication Manual, 6th edition.

In the body of the manuscript, cite the reference by author and publication date. Examples are provided below.

- One work by one author: (Smith, 1983)
- One work by multiple authors: (Smith, Jones, & Miller, 1983)
  - For subsequent citations, one work by three or more authors can be cited as: (Smith et al., 1983)
- One work by six or more authors: (Smith et al., 1983)
- Two or more works within the same parentheses
  - Two or more works by the same author should be arranged by year of publication: (Smith, 1983, 1987)
  - Identify works with the same author and same publication date with suffixes: (Smith, 1987a, 1987b)
  - Two or more works by different authors should be organized alphabetically, as they appear in the reference list: (Hart & Steinman, 2000; Smith, Jones, & Miller, 1987)

The reference list should be organized alphabetically and should come at the end of the article. A general outline of the entry is as follows: Author, A. A., Author, B. B., & Author, C. C. (year). Title of article. *Title of periodical*, volume, pp-pp. doi: xxxxx. More specific examples are provided below.

## □ Journal Article:

Tsai, M., & Wagner, N. N. (1978). Therapy groups for women sexually molested as children.

*Archives of Sexual Behaviour*, 7, 417-427. doi: 10.1037/0096-3445.134.2.258 □ Book:

Millman, M. (1980). *Such a pretty face*. New York: W.W. Norton.

□ Book chapter:

Zirkel, S. (2000). Social intelligence: The development and maintenance of purposive behavior. In R. Bar-On & J. D. Parker (Eds.), *Handbook of Emotional Intelligence* (pp. 3-27). San Francisco, CA: Jossey-Bass.

Examples of other types of references should refer to the Style Manual for the American

**Illustrations.** Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

300 dpi or higher

Sized to fit on journal page

EPS, TIFF, or PSD format only

Submitted as separate files, not embedded in text files

**Color Illustrations.** Color art will be reproduced in color in the online publication at no additional cost to the author. Color illustrations will also be considered for print publication; however, the author will be required to bear the full cost involved in color art reproduction. Color reprints can only be ordered if print reproduction costs are paid. Print Reproduction: \$900 for the first page of color; \$450 per page for the next three pages of color. A custom quote will be provided for articles with more than four pages of color. Art not supplied at a minimum of 300 dpi will not be considered for print.

**Tables and Figures.** Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files (appended to the end of the manuscript, in APA style). A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet. Tables MUST be a) properly formatted, b) coherently organized, c) legible, and d) relevant. Any acronyms or abbreviated terms must be spelled out in the Note below the table (even if the acronyms have already been spelled out in the body of the manuscript). Tables should NOT simply be cut-and-pasted computer output. Tables that are completely redundant with the text are typically unnecessary. Consider whether each table (and figure) provides important information that complements the text.

**Proofs.** Page proofs are sent to the designated author using Taylor & Francis' Central Article Tracking System (CATS). They must be carefully checked and returned within 48 hours of receipt.

**Reprints and Issues.** Reprints of individual articles are available for order at the time authors review page proofs. A discount on reprints is available to authors who order before print publication. Each corresponding author will receive 1 complete issues in which the article publishes and a complimentary PDF. This file is for personal use only and may not be copied and

disseminated in any form without prior written permission from Taylor and Francis Group, LLC.

Authors for whom we receive a valid email address will be provided an opportunity to purchase reprints of individual articles, or copies of the complete print issue. These authors will also be given complimentary access to their final article on *Taylor & Francis Online*.

**Open Access.** Taylor & Francis Open Select provides authors or their research sponsors and funders with the option of paying a publishing fee and thereby making an article fully and permanently available for free online access – *open access* – immediately on publication to anyone, anywhere, at any time. This option is made available once an article has been accepted in peer review. Details can be found on the journal's Taylor & Francis webpage.

## **Appendix B: Semi-structured interview schedule**

- Can you start by telling me about how you came to be on this treatment order? (*Prompts: what was happening in your life before? Who was in your life?*).
- If you think about your life so far can you tell me about things that have been happy or enjoyable and also things that have been more difficult or uncomfortable for you? (*Prompts: How did you feel? How do you feel about yourself and what has happened in your life?*).
- What was happening in your life during the first time you were involved with the police? (*Prompts: How did other people view you at the time? How did you feel about what other people were thinking of you? How did you cope with that?*)
- Tell me about when you were last in trouble with the police? (*Prompts: How did other people view you at the time? How did you feel about what other people were thinking of you? How did you cope with that?*)
- What advice would you give to someone who has recently come into a similar situation to you?



## Appendix C: Demographic information sheet

THE UNIVERSITY of EDINBURGH

The  
appropriate  
NHS logo to  
added

### Information about you

1. Today's date:        /        /2016
2. Age: .....
3. Is English your first language, or are you proficient in speaking English?  
Yes/No
4. Which of these groups do you belong to (please circle)?  
  
White Scottish/ British      Other White      Mixed White and  
other  
  
Black Scottish/ British      Other Black      Chinese or other ethnic  
group  
  
Other .....
5. Marital status (please circle all that apply):  
  
Single      Married      In a relationship and living together  
  
Divorced/separated      In a relationship but not living together  
  
Civil partnership      Widowed
6. Do you have any children? NO YES    **If yes, how many?**  
.....  
  
Are you currently pregnant? NO YES



7. Where do your children live? (please circle all that apply)

With you      With their dad      With other family member

With foster carers      With their adopted parents      On their own

Other .....

8. Where do you live?

Own home    Rental housing    With partner/family/friends in  
their home

B&B or hostel    Refuse or shelter    Other  
.....

9. What school have you finished?

I have not finished any school    Primary school    High school

College/apprenticeship    University    Other  
.....

10. What type of Community Order are you currently on:

Community Payback Order with requirement (please specify type e.g.  
supervision, unpaid work, drug or alcohol  
treatment).....

DTTO    License

11. How many previous criminal convictions do you have?

.....

What were they for (circle all that apply)?

Theft/shoplifting    Drug related    Driving related    Prostitution

Fraud    Harassment    Breach of the peace    Breach of release  
conditions/order

Child neglect/ abuse    Kidnapping    Sexual offences    Murder/  
attempted murder

Robbery    Assault    Fire raising/setting

Other .....

12. Have you been to prison?    NO    YES    If yes how many times?

.....

13. What was your longest sentence? ..... months

..... Years

14. As a child/young person did you ever experience (circle all that apply):

Getting physically hurt/ abused

Getting sexually hurt/ abused

Getting emotionally hurt/ abused (e.g.  
physically,

being bullied, humiliated, rejected)

Witnessing others getting

sexually or emotionally hurt

Not having enough food/ warm clothes    Your parents/carers abusing  
drugs/ alcohol

Your parents/carers struggling with mental health difficulties

Being left at home alone without knowing  
where your parents were or when they  
would be home

15. As an adult have you ever (circle all that apply):

Been physically hurt/ abused	Been sexually hurt/ abused
Been emotionally hurt/ abused (e.g. physically, bullied, humiliated, rejected)	Witnessed others getting sexually or emotionally hurt

16. How would you describe your general health? (please circle one)

Poor	Below Average	Average	Above Average
Excellent			

17. Do you consider yourself to have or have you been diagnosed with mental health difficulties (e.g. depression, anxiety, Post-Traumatic Stress disorder)

NO	YES
----	-----

18. Are you currently taking any medication for mental health difficulties?

YES	NO
-----	----

19. Are you currently having any psychological treatment for mental health difficulties?

YES	NO
-----	----

## **Appendix D: Thesis Proposal**



### **Doctorate in Clinical Psychology**

Thesis Research Proposal

Provisional Thesis Title: An exploration of shame in violent female offenders

Exam number: B066818

Author: Emma Macey

#### **Allocated Thesis Project Supervisors**

Clinical: Mette Kreis

Academic 1: Emily Newman

Academic 2: Ethel Quayle  
(where applicable)

Others involved as part of project team (if applicable)

Proposed setting(s): Forth Valley Community Justice Services (Falkirk, Stirling and Clackmannanshire), the Willow project in Edinburgh and Tomorrow's Women in Glasgow.

Anticipated Month & Year of Submission of Thesis: 1<sup>st</sup> May 2017

Version (date): 15/07/2015

Word count: 4232

#### **Introduction**

##### **Needs of female offenders**

Female offenders have extremely high levels of complex health and social needs, some of which are distinct from the needs of male offenders and therefore require attention and research that focuses on the context of both their lives and offences (Blanchette and Brown, 2006; DeHart, Lynch, Belknap, Dass-Brailsford and Green, 2014; Fazel, Bains and Doll, 2006; McClellan, Farabee and Crouch 1997; Light, Grant and Hopkins, 2013; O'Brien, Mortimer, Singleton and Meltzer, 2001). In a Scottish health review at Cornton Vale, 98% of women had substance misuse difficulties and 80% had mental health

problems (Scottish government, 2007). Higher levels of mental health problems (e.g., anxiety, psychosis, posttraumatic stress disorder, depression, self-harm and suicidality) are found in female offenders than in both the general population and male offenders (Fazel & Seewald, 2012, O'Brien et al., 2001; Sington et al., 1998). Further, in England and Wales a fifth of male prisoners compared to half of female prisoners were shown to be taking prescribed medication for mental health problems (Sington et al., 1998).

It has been suggested that the higher levels of mental health problems found among female offenders may be related to their higher rates of victimisation experiences (Gelsthorpe et al., 2007). Therefore, if mental health problems are related to victimisation and trauma then it is vital that we address the individual's trauma experiences in order to address her mental health problems. This is consistent with research showing the importance of using a trauma-informed intervention model with female offenders (Covington & Bloom, 2006).

Blanchette and Brown (2006) suggest that in order to facilitate female offenders to desist from offending, and enable them to develop skills and confidence to engage in treatment, we must first understand the distinct needs of women. This requires research to focus on both criminogenic (i.e., treatable dynamic risk factors for reoffending) and non-criminogenic needs (not associated with offending or a reduction in recidivism) (Moffat, 2005). There is a limited amount of research that investigates the specific needs of female offenders (Blanchette & Brown, 2006). Further, rehabilitation models are still primarily based on risk management models (Andres, Bonta, & Wormith, 2006) principally based on knowledge and theory of male offending rather than focusing on needs (criminogenic and non-criminogenic) that may be salient to women. It is therefore important to conduct further research with women offenders to determine relevant needs and how these may be related to risk of offending.

### **Recent changes in Scotland**

Over the past ten years the number of female prisoners in Scotland has more than doubled from 199 in 1999 to around 424 in 2010 (Scottish Government, 2011). This has led to increased attention on needs and risks of women offenders; consequently the Commission on Women Offenders (CWO, 2012) was established by the Scottish Government and tasked with making recommendations for improving outcomes for women in the criminal justice system. The report acknowledges gender differences in offenders stating that female offenders are a lower risk to public safety, have higher mental health and drug problems and are at higher risk of past and present victimization, sexual and physical abuse. The CWO therefore concluded that in order to reduce reoffending and improve outcomes for communities both services and programmes need to be tailored to meet the unique needs of women offenders. This has led to changes in the female custodial estate across Scotland. For example, it has recently been announced that the plans for a new female prison in Inverclyde have been rejected and replaced with plans to invest in smaller regional community based facilities instead (see: <http://news.scotland.gov.uk/News/Plans-for-female-prison-in-Inverclyde-will-not-go-ahead-14ef.aspx>). These changes will increase the number of female offenders within communities and highlight the importance of conducting research in these settings. This will help to identify changing needs and help shape treatment options and inform evidence-based treatment and interventions (Bartlett et al, 2015).

### **Shame**

Lewis (1971) was the first to distinguish between the moral emotions of shame and guilt. She suggested that guilt focuses on a negative evaluation of a specific behavior whereas shame emphasizes a negative evaluation of the global self. Although both are negative emotions the emphasis on the self elicited by shame can lead to intra-psychic pain because the individual's core self is at stake. Research consistently demonstrates that a wide array of psychological symptoms is linked with the experience of shame. These include anxiety, eating disorder symptoms, depression, low self-esteem, PTSD and suicidal ideation (e.g., Andrews et al., 2000). Shame is also a common consequence of experiences of complex trauma (Courtois, 2004), which has a high prevalence in female offenders (Carlson & Shafer, 2010).

As suggested by Tangney, Stuewig and Mashek (2007), shame is usually accompanied by a sense of smallness, worthlessness and powerlessness. Shame as a social emotion has been emphasised by Gilbert, Pehl and Allan (1994) who state that an inadequate self is pictured as if viewed through another who is more powerful, capable and rejecting. The self is viewed outside of what is acceptable and as incapable of change leading to a desire to hide from the social world. This results in frustration, rage and fury against the critical other.

It is therefore unsurprising that past research consistently demonstrates that shame proneness is linked to anger and hostility (Andrews et al. 2000, Bennett, et al. 2005, Harper and Arias 2004, Paulhus et al. 2004, Tangney and Dearing 2002, Tangney, Stuewig and Hafez, 2011), which is related to violent offending (Howells, 2011). High shame proneness has also been linked to an increased risk of recidivism (Hosser, Windzio & Greve, 2008). However, more recently Tangney, Stuewig & Martinez (2014) showed that shame is multifaceted and that proneness to shame did not predict reoffending. The authors suggest that shame can have two faces. Shame proneness can prompt people to blame others rather than taking personal responsibility, which is a risk factor for recidivism. However, shame can also motivate people to withdraw or hide which can inhibit recidivism through increased downtime and the ability to rethink and better anticipate shame. However, due to the limited scope of the study the impact of internalised shame cannot be acknowledged or discussed and therefore warrants further investigation.

Previous literature consistently demonstrates the high prevalence of interpersonal violence and abuse histories in female offenders (e.g. Carlson and Shafer, 2010). It has been suggested that experiences of shame such as sexual or physical abuse can become central to an individual's identity and life story (Pinto-Gouveia and Matos, 2011) and that early shame experiences may be internalised into a negative working model of the self as forms of self; condemnation, devaluation, critical feelings and cognitions (Blatt and Zuroff, 1992). Criticism from another individual (especially if considered a valid undesirable aspect of self) can often lead to the experience of shame (Gilbert, 1998; Tangney, 1995). In this instance individuals may feel personally shamed but may also feel angry and externalize the blame to the critical other (Tangney et al., 1996) leading to a counter attack and violence (Tedeschi & Felson, 1994). When considering the current literature it is apparent that female offenders have complex histories linked to shame experiences. Research also demonstrates the link between shame and aggressive behaviors, however, shame in violent female offenders has not been explicitly investigated and the exact nature and meaning of this remains unexplored. It has been argued that qualitative methodologies are especially useful for exploring phenomena we know little about (Hedderman et al., 2011) and also for the investigation of shame (Retzinger, 1995) due to the context dependent nature of this emotion.

To the researcher's knowledge there are no qualitative studies explicitly investigating shame and violence in female offenders and this requires further exploration. The need to further investigate shame and violence in female offenders is also highlighted by Kreis (2013) who demonstrates the importance of shame in the lives of female offenders. Kreis (2013) used a grounded theory approach to investigate close relationships and the related psychological processes that impact on women's substance misuse and offending. A provisional model was constructed which hypothesised the complexity between substance misuse, offending, family disconnection, dysfunctional intimate partner relationships and loss of children in the context of trauma, insecure attachment and shame.

The model suggests that for some women substance misuse may begin within the context of abusive and rejecting parenting, resulting in unmet psychological needs such as feeling loved and connected to others, and thus insecure attachment. This may lead to substance misuse as a way to regulate painful emotions such as shame, and offending to fund their drug habit. The model is based on women offenders with drug addiction. In this model women use substances to regulate emotions, however, the model does not yet discuss other ways women could regulate feelings of shame and the impact that this could have on their risk of reoffending. Kreis (2013) emphasises the need to investigate the role of trauma and shame in relation to offending behaviour in different female offender populations, including violent offenders. She states that there is some research to suggest that high levels of shame increase the risk of reoffending (Hosser, Windzio, & Greve, 2008) but that few studies have explored this in relation to female offenders.

Shame in violent female offenders is poorly understood and the researcher is unaware of any study investigating this phenomenon. Tangney, Stuewig and Martinez (2014) suggest that the painful experience of shame could either be debilitating and have a destructive nature or be constructive and a potential strength. The researchers emphasize the importance of shame and the need for future research within this area. However, the study combines both male and female participants and does not acknowledge that the needs of female offenders are often distinct from that of their male counterparts (Blanchette and Brown, 2006). The proposed research will therefore use qualitative methods to explore shame in violent female offenders.

Increased knowledge and understanding of shame in violent female offenders may have several implications. It could potentially help inform appropriate and effective interventions for women offenders and thus reduce recidivism (Hollin & Palmer, 2006). More effective interventions could have social, economical and personal benefits for offenders, their families and the general public. Further, women offenders have high levels of mental health problems (Scottish government, 2007) and an increased understanding of these specific needs could help to inform service planning. This is of particular importance in light of the recent changes to the female custodial estate across Scotland.

## **Methodology**

### **Design**

This research is qualitative which has been shown to be suitable for investigation of poorly understood phenomenon (Hedderman, Gunby and Shelton, 2011) and is therefore suitable to explore shame in violent female offenders. Semi-structured interviews using Charmaz's (2006) social constructivist version of grounded theory will be utilised. Grounded theory allows the researcher to move from data to theory allowing new theories

to emerge. This is an appropriate methodology for the proposed study because it opens up a space in which new contextualized theories can develop and thus enhance our understanding of shame in violent female offenders. Charmaz's (2006) socially constructed version of grounded theory will be used because it acknowledges the role of the researcher when determining categories and emphasises the importance of the interaction between the data and researcher for discovering ideas and concepts.

### **Participants and recruitment**

Women offenders involved with Criminal Justice Services (CJS) in Falkirk, Stirling and Clackmannanshire; Tomorrow's Women and potentially Edinburgh Willow project will be invited to participate in the study. There are currently (July 2015) 199 female offenders across the four services that have agreed to be involved in the project.

Recruitment will take place as follows:

- Participants who are eligible for the study will be identified using information gained from staff members (i.e. key workers, case managers and psychologists in the service).
- Information packages will be passed onto key workers who will then identify women interested in the study. Key workers will then provide interested participants with a study information leaflet and also verbal information about the research. Participants will then be given at least two weeks to read through the information and consent to engaging in the study.
- Staff members will arrange a time and date for the interview that is convenient for participants and staff for example coinciding with other activities at the center.
- Participation will be both confidential and voluntary and all interview data anonymised using pseudo-names and redaction where appropriate. It will be made clear to participants that taking part in the study or not will not affect their treatment with the service or their access to psychological therapy.

### **Inclusion criteria:**

- Participants must be at least 18 years old.
- Be able to both speak and understand the English language.
- Have a past history of violent offending. The definition of interpersonal violence in the HCR-20 v3 manual will be used to define violence and inform appropriate recruitment. "interpersonal violence, defined as actual, attempted, or threatened infliction of bodily harm on another person. Bodily harm includes both physical and serious psychological harm...psychological harm includes fear of physical injury, and other emotional, mental or cognitive consequences of the act in question." (Douglas, Hart, Webster, & Belfrage, 2013, p. 36).

### **Exclusion criteria:**



- Acute psychotic symptoms.
- Intoxicated during consent and at the interview stage.
- Have a learning disability.

### **Data collection:**

All forms will be read out and filled in with the support of the researcher:

- 1. Offending history** – Self-reported offending history will be collected at interview and informed consent will be obtained in order to confirm this with key workers and official records.
- 2. Demographic information** - will be collected at the beginning of the interviews using a structured questionnaire designed for the purpose of the study. This will look at age, nationality, relationship/marital history and current status, children and child status (e.g. living with the women or accommodated), housing, education, employment, financial support, substance misuse, trauma (e.g. experience of childhood and adulthood victimization), mental health, and self-harm.
- 3. Semi-structured interview** - A semi-structured interview will be designed for the purpose of the study. Questions and prompts will be open-ended to allow for rich data to be collected that cover broad areas relating to shame and offending. The interview will start with a question aimed at engaging the individual and will end on a question aimed at reducing distress and closing the interview. All interviews will be audio recorded and transcribed verbatim by the researcher. NVivo Version 10 software (Qualitative Solutions Research, 2012) will be used to aid analysis. Any information that is identifiable will be removed and pseudo names will be used. The information will be stored in a lock draw during transcription and will be securely destroyed after transcription in accordance with the Data protection Act.

### Sample Size

The sample will be purposefully selected and will focus on females that have committed a violent crime. The researcher will aim for a sample size of 12, which is considered adequate to achieve theoretical sufficiency (Guest et al., 2006). In accordance with Charmaz (2006) theoretical sampling will be employed to refine emerging categories.

The study has the support of the lead of the Forth Valley Criminal Justice Service, which covers three services across Falkirk, Clackmannanshire and Stirling. The clinical psychologist at Tomorrows Women's centre in Glasgow is also fully supportive of the project and recruitment process. The clinical psychologist at the Willow project has been contacted and the researcher is awaiting further confirmation. It has been advised that staff will be able to help select suitable participants, advertise the study, and facilitate meetings with the women. The researcher will keep in regular contact with staff in order to promote the study and discuss any difficulties or questions that may arise.

Recruiting across all five services will widen the pool of suitable participants. There are currently (June 2015) 199 female offenders across the four services.

The researcher will be transparent about her dual role as a postgraduate student and trainee clinical psychologist. It will be made clear to all participants that participation in (or declining of) the study will not affect treatment or their access to psychological therapy within the criminal justice services.

### **Analysis**

The transcribed interviews will be analysed using grounded theory methods following guidelines by Charmaz (2006). NVivo Version 10 software (Qualitative Solutions Research, 2012) will be used to aid analysis. Notes will be written during and after the interview to capture information potentially missed by audio-recording alone e.g. body language. In accordance with Charmaz (2006) transcripts will initially be coded line-by-line and then common codes will be organised into higher-order categories. Constant comparative analysis of codes will allow for themes to develop. Reflective memos will be written throughout the process of data collection and analysis. Iterative coding will also be used to ensure that the understandings are coming from the data; initial codes will be re-examined to see if they fit with broader emerging themes. The findings of the study will be validated by triangulation, the anonymised interview transcript will be cross-coded by a clinical psychologist supervising the first author's thesis, this will ensure internal validity. The themes will also be cross-validated through a second literature review.

### **Project Management: Timetable**

Year of study	Month	Stage	Notes
1st	July 2015	Submission of research proposal	- Use relevant suggestions to update proposal and add into the ethics application.
1st	July –August 2015	Prepare resources and relevant ethics applications.	- Develop participant information forms, including seeking feedback regarding readability. - Assemble resources needed, e.g. NVivo Version 10 software. - Finalise recruitment procedure. - Determine final list of what participant access permissions will need to be obtained, e.g. Council, IRAS, NHS.
1st	End of August 2015	Submit ethics	- Wait 6 weeks for response
2nd	End of October 2015	Data prep work	- Plan structure of thesis - Create secure database - Establish secure location for physical data storage
2 <sup>nd</sup>	October 2015 - September 2016	Recruitment and data collection (pending favorable ethical decision) Write up - Methodology - Introduction	- Input data into database - Start first half of introduction  - Supervisor feedback re methodology

2 <sup>nd</sup>	March 2016	Systematic review	-Refine question -Plan
2 <sup>nd</sup>	Sept 2016	Write up - Results - Re-draft introduction	- Supervisor feedback re results
3 <sup>rd</sup>	July – September 2016	Data transcription and analysis	- Descriptive analyses - Data analysis using grounded theory methods.  - Supervisor feedback re analyses
3 <sup>rd</sup>	Nov 2016 – Jan 2017	Systematic write up - Introduction - Analyses	- Supervisor feedback re introduction and analyses
3 <sup>rd</sup>	Feb 2017	Finish systematic review	- Discussion - Supervisor feedback
3 <sup>rd</sup>	March 2017	Final thesis write up	- Finish outstanding sections - Finalise referencing - Formatting - Binding
3 <sup>rd</sup>	April 2017	Final thesis draft to supervisors	
3 <sup>rd</sup>	May 2017	Final submission of thesis	
3 <sup>rd</sup>	June - July 2017	Prepare for viva Plan disseminations	- practice mock vivas with supervisors - commence application for relevant publications
3 <sup>rd</sup>	Aug 2017	Submit for publications	

## **11) Management of Risks to Project**

### **1. Recruitment difficulties and non-attendance of interviews**

There are a limited number of female offenders who have committed a violent crime. Also, women offenders often lead chaotic lives, which could impact on their ability to take part in the study and thus increase the risk of non- attendance. The risk will be minimised by:

- Early recruitment.
- Having the support of staff to help promote the study and recruit suitable participants.
- Arranging interviews to fit with treatment schedules.
- Recruiting from all criminal justice services in Forth Valley and Tomorrow's Women center in Glasgow to widen the pool of suitable participants.
- Promoting the study to the women as a way to get their voice and needs heard, which may help improve services for women offenders in the future.

### **2. Distress to participants**

Some participants may become distressed during the interviews as the questions look at past experiences and offences. Therefore participants will be given the option to terminate the

interview at any point and will be immediately debriefed or offered this at a later date. The researcher will also work closely with staff in the services to ensure emotional support throughout the study.

The material covered in the interviews may contain sensitive information and therefore participants will be given a sheet containing telephone numbers of internal and external support lines. Additionally, the psychologist in the service will be aware of their participation in the study and potential need for support after the interview.

### **3. Management of disclosures**

At the beginning of the interview participants will be informed that standard clinical confidentiality procedures will apply (both verbally and in the consent form). They will be informed that the interview will be confidential unless they disclose anything that suggests that there is a risk of harm to self or others or that a crime has been or is about to be committed. In this instance the researcher will need to inform the appropriate authority and members of staff at the service.

### **4. Loss of data**

During the recording of interviews equipment could malfunction resulting in loss of data. This limitation will be overcome by using two recording devices. The data will also be frequently backed up to prevent loss of data.

### **Knowledge Exchange**

At the end of the study participants will receive a written summary of the results. The results will also be disseminated to the criminal justice service through both a summary report and presentations. The results will also be disseminated through the presentation of research papers at relevant national and international conferences, and journal articles will be submitted for publication in relevant scientific journals (e.g. International Journal of Forensic Mental Health; Legal and Criminological Psychology).

### **What are the anticipated benefits or implications for services of the project?**

The major contributions of this study will be to investigate shame and violent offending. To my knowledge no previous research has investigated this. The project could therefore help to highlight pathways to violent crime and risk for violent recidivism for female offenders, and inform on factors that may be relevant intervention targets with this population.

### **Are there any potential costs to this project?**

Minimal costs for stationary and printing will be required which will be covered by the NHS Forth Valley. These costs will be approximately £50.

## **Appendix E: Participant information sheet**



THE UNIVERSITY *of* EDINBURGH

The appropriate  
NHS logo to be  
added

### **Exploring thoughts, feelings and behaviors of women in the criminal justice system**

#### **Invitation to take part in research study**

- The study will look at thoughts, feelings and life experiences of women in the criminal justice system in relation to behaviours that other people may perceive as aggressive and harmful, and which may have lead to police involvement.
- The study is conducted by Emma Macey who is a Trainee Clinical Psychologist in NHS Forth Valley and a psychology postgraduate student at the University of Edinburgh.
- If you would like to take part in the study Emma will meet you for one-hour to collect consent, background information and conduct the interview. The interview will take place in the building you usually meet your keyworker.
- Taking part in the study is completely voluntary, confidential and anonymous.
- Taking part or deciding not to take part won't affect your current care or access to psychological therapy. More information about the study is provided on the following page or you can ask your key worker for more information.



THE UNIVERSITY of EDINBURGH

The appropriate NHS logo to be added

## **Participant information sheet**

### **1) What is the purpose of the study?**

The study is exploring females' thoughts, feelings and life experiences in relation to behaviours they have engaged in that other people may perceive as aggressive and harmful, and which may have led to police involvement. This currently under researched area requires further exploration, to help understand the nature of female offenders needs, which could lead to informing services and the psychological treatment of female offenders.

### **2) Why have I been given this information?**

We are looking for women involved in the criminal justice system across Glasgow, Edinburgh and Forth Valley who have engaged in behaviours that others may perceive as aggressive and harmful to take part in this study.

### **3) Do I have to take part?**

Your participation is entirely voluntary. If you do decide to take part, you will be asked to sign a consent form. You are free to withdraw from the study at any time you choose without giving a reason. You are under no obligation to answer any questions which make you uncomfortable. If you decide to become involved in this project it will not delay or impact on your current treatment or your criminal justice order.

### **4) What does taking part involve?**

If you decide to take part in the study I will interview you in the same building where you would normally see your keyworker. This will take up to one hour and will be audio recorded.

At the beginning of the interview you will be given a consent form and asked to sign this if you would like to participate in the study. You can also indicate on the consent form if you would like your GP to be informed of your participation, however this is optional. You will then be asked some basic background information (e.g. your age, living situation, health status and adverse life experiences). During the interview you will be asked about your thoughts, feelings and life experiences in relation to behaviours you have engaged in that other people may perceive as aggressive and harmful, and which may have led to police involvement.

If you become upset during the interview you can ask for it to be stopped. Where ever possible keyworkers and service psychology staff will be available to offer support. Also, if you would like to talk to me at a later date about the interview and anything it may have brought up, please let your keyworker know and this will be arranged in the same location as your original interview.

### **5) What are the possible benefits of taking part?**

There are no direct benefits to you in taking part in this study, however, hopefully you will find the experience interesting and positive. Exploring issues related to women involved in the criminal justice services will help us understand the needs of female offenders better, which may help to inform services for women.

#### **6) What are the possible disadvantages of taking part?**

There are no direct disadvantages to you taking part in the study, however it will take approximately one hour of your time. It could be upsetting talking about your life history in the interview, but you will have the opportunity to discuss any upsetting issues at the time or at a later date that suits you. You will also be free to postpone or withdraw from the study at any point without explaining why. After the interview you can also talk to your keyworker or psychologist in your service.

#### **7) Confidentiality**

The information gathered during the interview will be completely anonymous. Data collected will be held in secure conditions and only my research supervisors and I will have access to it. Audio recordings will be securely transcribed removing names and identifying features. Audio recordings will be destroyed immediately after transcription. Information will be analysed in confidence and your personal details will not be shared with other people. Direct quotes may be used, however, no names will appear in any part of the report and you will not be identifiable.

All information that you provide at interview will be confidential, unless you tell me about potential risk of harm to yourself or others, including children, or about undisclosed criminal activity. I will then have to inform the appropriate authorities including your keyworker.

The research data gathered will be destroyed in accordance with standard professional guidelines after the study has been concluded.

#### **8) What will happen to the results of the study?**

When the data has been analysed the main findings will be summarised and sent to your key worker. The information will then be passed onto you. You will then be able to look through these findings and add your own comments and suggestions to them. Within one year of the study finishing the results will be available and a copy will be sent to your keyworker and offered to you. The results will be based on the information given by all women interviewed. It will not identify any one woman but will describe overall experiences. The results will also be presented to local criminal justice services, other researchers, and criminal justice and mental health professionals.

#### **9) Who is organising and funding the research?**

Emma Macey is a trainee Clinical Clinical Psychologist from the Department of Clinical Psychology at Edinburgh University and NHS Forth Valley. As part of her doctoral degree she is required to conduct a research project. The current study is supervised by Dr Emily Newman, Clinical Psychology Researcher director, Dr Ethel Quayle, Senior Lecturer and Clinical Psychologist, and Dr Mette Kreis, Clinical Psychologist. The research is funded by NHS Education for Scotland and has been approved by the South East Scotland Research Ethics Committee 01. If you have any comments or complaints about the research, please contact Dr Emily Newman on 0131 651 3945.

## **10) Contacts**

If you would like to discuss this study with someone independent of the study team please contact Dr. Elizabeth Flynn on 01324 616211 or email on [elizabethflynn@nhs.net](mailto:elizabethflynn@nhs.net).

If you wish to make a complaint about the study please contact:

*Appropriate NHS complaints department to be added*

## **11) Where can I get more information or sign up for the study?**

Thank you for taking the time to read and consider this request. Please tell your keyworker if you are interested in hearing more about the study or in taking part. If you are interested in taking part your key worker will organize a time and date for the interview.



## Appendix F: Staff information sheet



THE UNIVERSITY *of* EDINBURGH

### STAFF INFORMATION SHEET

#### **Purpose of study**

The purpose of the study is to find out more about shame and violence in female offenders. Some research shows that high levels of shame can be related to an increased risk of reoffending. However, currently research is scarce and no research explores shame and violence in female offenders. More information is therefore needed to explore this further. Such information will help inform local and wider services about women offenders' needs.

#### **Who is doing this study and what is it for?**

The study will be conducted by Emma Macey who is clinical psychology doctorate student at University of Edinburgh and a Trainee Clinical Psychologist in NHS Forth Valley. The study is part of Emma's doctoral thesis and is supervised by Dr Emily Newman, Clinical Psychology Researcher director, Dr Ethel Quayle, Senior lecturer and Clinical Psychologist, and Dr Mette Kreis, Clinical Psychologist. The research is funded by NHS Education for Scotland. If you have any comments or complaints about the research, please contact Dr Emily Newman on 0131 651 3945.

#### **Who will take part in the study?**

All women in the criminal justice services across Forth Valley, Tomorrow's Women in Glasgow and the Willow project in Edinburgh who have engaged in violent behaviours will be invited to take part in this research. The definition of interpersonal violence in the HCR-20 v3 manual will be used to define violence and inform appropriate recruitment:

"Interpersonal violence, defined as actual, attempted, or threatened infliction of bodily harm on another person. Bodily harm includes both physical and serious psychological harm...psychological harm includes fear of physical injury, and other emotional, mental or cognitive consequences of the act in question" (Douglas, Hart, Webster, & Belfrage, 2013, p. 36).

Participants must be at least 18 years old and be able to speak and understand English. They cannot have a learning disability, suffer from an acute psychotic disorder or be intoxicated at consent or interview. Participating in the study will be completely anonymous, confidential and voluntary.

#### **How will the study be conducted?**

Eligible participants will be identified through information from staff members (keyworkers and case managers) and will be provided with a study information leaflet and verbal information about the study by their keyworkers. Participants will be given at least 2 weeks to decide if they would like to take part in the study. If they decide to take part, staff should contact Emma to arrange the interview.

### **What is expected of participants taking part in the study?**

At the beginning of the interview Emma will collect basic background information (e.g. age, living situation, health status, and adverse life experiences). Emma will then interview participants, which will take up to one hour.

This will be conducted in a staffed building preferably in the same building that participants have their key worker sessions.

During the interview participants will be asked about their thoughts, feelings and life experiences in relation to behaviours they have engaged in that other people may perceive as aggressive and harmful, and which may have led to police involvement.

If the participant becomes upset during the interview they will be able to stop the interview at any time. If participants would like to talk to Emma about the interview at a later date a future meeting will be arranged. Emma will also liaise closely with staff including psychology staff to ensure that all participants are supported emotionally throughout the study.

### **What is required of staff?**

Staff are asked to assist with identifying eligible participants and give potential participants verbal and written information about the study. Staff will also be asked to contact Emma to inform her of any interested participants. Where possible staff will be asked to help arrange interview rooms and times/dates of the interview to coincide with key workers/staff availability. This will help with the attendance of participants and ensure the safety of participants and Emma.

### **When will the study take place?**

Emma plans to recruit participants and conduct the interviews between January and September 2016.

### **Contact information**

Please contact Emma if you require any further information about the study or to inform her of potential participants:

Emma Macey, Trainee Clinical Psychologist Forth Valley Adult Clinical Psychology,  
Falkirk Community Hospital, Major's Loan, Falkirk, FK1 5QE Tel: 01324 614349  
Email: [emma.macey@nhs.net](mailto:emma.macey@nhs.net)

## Appendix G: Sample coding

Interview transcript	Line-by-line coding	Higher order codes
<p><u>Participant:</u>            “It was difficult to speak about because, they should of took care of me, you know so I didn’t want to tell. People did know, I did say but I didn’t want to get help, I was scared to talk about it, you know.”</p>	<p><i>Feeling uncared for by parents.</i></p> <p><i>Finding it difficult to talk about sexual abuse because she felt her parents did not care about her.</i></p> <p><i>Asking for help whilst also not feeling able to receive help due to fear.</i></p>	<p><b>Insecure, uncompassionate and unavailable relationships in childhood.</b></p> <p><b>Being unable to utilise relationships to talk about sexual abuse.</b></p> <p><b>Experiencing difficulties with seeking help.</b></p>
<p><u>Researcher:</u>            “So who did you tell?”</p>		
<p><u>Participant:</u>            “Um, over the years I’ve went for help, but I only maybe went once or twice and then I was going back to my house on my own and it was making me drink more and then I wouldn’t engage and I still, I felt a lot of shame, I felt dirty you know, um, just even saying the word I was sexually abused. But there’s a lot of shame in the word you know.”</p>	<p><i>Attempting to seek help</i></p> <p><i>Using alcohol after failed attempts seeking help</i></p> <p><i>Using alcohol to regulate negative emotions/ shame</i></p> <p><i>Feeling alone</i></p> <p><i>Shame preventing engagement with service</i></p> <p><i>Feeling dirty due to sexual abuse</i></p> <p><i>Feeling shameful about sexual abuse</i></p>	<p><b>Experiencing difficulties with seeking help.</b></p> <p><b>Using substances to try and regulate painful negative emotions including shame.</b></p> <p><b>Feeling alone and isolated.</b></p> <p><b>Shame leading to alcohol use preventing help seeking and engagement with services</b></p> <p><b>Sexual abuse leading to feelings of shame</b></p>

## Appendix H: Consent form



THE UNIVERSITY *of* EDINBURGH

### Exploring thoughts, feelings and behaviors of women in the criminal justice system

#### Consent Form

If you would like to take part in the research study, please read and sign this form. Also please put your initials in each box.

- 1) I confirm that I have read/been read and understand version 2 of the information sheet dated 17/12/2015 for the above study and have had the opportunity to ask questions.
- 2) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
- 3) I understand that the interview will be digitally-recorded. My name will not be used in any written transcripts and the digital recordings will be destroyed at the end of the research period.
- 4) I would like my GP to be informed about my participation in this study.
- 5) I understand information will be treated anonymously and in confidence except when there are disclosures relating to potential harm to self or others including children or to undisclosed criminal activity.
- 6) I understand that direct anonymous quotes will be used in the study.
- 7) I understand that participation in this project will not affect my current care provision or criminal justice order.
- 8) I understand that relevant sections of data collected during the study may be looked at by individuals from the regulatory authorities and from the Sponsor (University of Edinburgh) or from the/other NHS Board(s) where it is relevant to my taking part in this research. I give permission for those individuals to have access to my records.
- 9) I agree to take part in the above study.

Name of person taking consent:

Service:

Name of participant:

Signature:

Date:

Original (x1) to be retained in site file. Copy (x1) to be retained by the participant.

## Appendix I: Lothian Research and Development approval

### University Hospitals Division

Queen's Medical Research Institute  
47 Little France Crescent, Edinburgh, EH16 4TJ

FM/GM/Approval

23<sup>rd</sup> March 2016

Dr Alana Davis  
Clinical Psychologist  
Willow Service  
Lauriston Building  
EH3 9HA



Research & Development  
Room E1.12  
Tel: 0131 242 3330

Email:  
R&DOffice@nhslothian.scot.nhs.uk

Director: Professor David E Newby

Dear Dr Davis,

**Lothian R&D Project No: 2016/0078**

**Title of Research:** Exploring thoughts, feelings and behaviours of women in the criminal justice system

**REC No:** 15/SS/0228

**Participant Information Sheet:**  
Version 3 Dated 9<sup>th</sup> January 2016

**Consent Form:**  
Version 2 Dated 17<sup>th</sup> December 2015

**Protocol:** Version 1 Dated 16<sup>th</sup> November 2015

I am pleased to inform you that this study has been approved for NHS Lothian and you may proceed with your research, subject to the conditions below. This letter provides Site Specific approval for NHS Lothian.

We note that this project includes a researchers who will require a NHS to NHS Proforma. The individuals concerned Emma Macey and Dr Kreis should contact our offices with a view to applying for the necessary documentation. Please note all final paperwork will have to be signed and returned to our R&D offices before the researchers can commence work on the project.

Please note that the NHS Lothian R&D Office must be informed if there are any changes to the study such as amendments to the protocol, recruitment, funding, personnel or resource input required of NHS Lothian.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please inform this office when recruitment has closed and when the study has been completed.

I wish you every success with your study.

Yours sincerely

A handwritten signature in black ink that reads 'Fiona McArdle'.

Ms Fiona McArdle  
Deputy R&D Director

cc: Ms Kirsty Pate, Willow Manager  
Miss Emma Macey, Chief Investigator

## Appendix J: Glasgow & Clyde Research and Development approval



Senior Research Administrator: Kayleigh Pender Telephone Number: 0141 23 21826 E-Mail: [Kayleigh.pender@ggc.scot.nhs.uk](mailto:Kayleigh.pender@ggc.scot.nhs.uk) Website: [www.nhsggc.org.uk/r&d](http://www.nhsggc.org.uk/r&d)

05 April 2016

Miss Emma Macey, Adult Clinical Psychology, Falkirk Community Hospital, Major's Loan, Falkirk, FK1 5QE

Dear Miss Macey,

### **NHS to NHS - Letter of Access for Research**

**Research & Development West Glasgow ACH Dalnair Street Glasgow G3 8SW**

---

As an existing **NHS employee** you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through **NHS Greater Glasgow and Clyde** for the purpose and on the terms and conditions set out below. This right of access commences on **05.04.16** and ends on **28.02.17** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to **NHS Greater Glasgow and Clyde** premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **NHS Greater Glasgow and Clyde** you will remain accountable to your employer **NHS Forth Valley** but you are required to follow the reasonable instructions of your nominated manager **Dr Anne McKechnie** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **NHS Greater Glasgow and Clyde** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **NHS Greater Glasgow and Clyde** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for

GN16A M013	NHS to NHS Letter of AccessNHS to NHS Letter of Access	Page 1 of 2
---------------	--	-------------

the health and safety of yourself and others while on **NHS Greater Glasgow and Clyde** premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Board via the **HR Department** prior to

commencing your research role at the Board.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

**NHS Greater Glasgow and Clyde** will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you **MUST** stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or



children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

**Kayleigh Pender**

Senior Research Administrator cc: **HR Department contact**

GN16A M013	NHS to NHS Letter of AccessNHS to NHS Letter of Access	Page 2 of 2
---------------	---	-------------


## Appendix: K: Stirling Research and Development Approval



Emma Macey  
emma.macey@nhs.net

**Social Services**  
Clackmannanshire / Stirling Council  
Lime Tree House,  
Alloa, FK10 1EX  
**Tel:** 01259 225017  
**Fax:** 01259 225004  
**Email:** vdesouza@clacks.gov.uk  
**Ref:** VDS/SSLD

**Date:** 29 February 2016

Dear Ms Macey

### RESEARCH ACCESS

Thank you for your research access request. We are grateful for the submission of the information requested and we have reviewed your documentation. We are now in a position to approve your request.

To progress this further, please contact Alistair Smilie, Team Leader, at your earliest convenience:

smilliea@stirling.gov.uk  
01786 233876  
Criminal Justice Service, Stirling Council, Municipal Buildings, 8 – 10 Corn Exchange Road,  
Stirling. FK8 2HU

At the conclusion of your research, we ask that you please provide the service with a summary of your findings. Please forward this to ssld@stirling.gov.uk.

We wish you well with your research.

Yours sincerely

A handwritten signature in black ink that reads 'Val de Souza'.

Val de Souza  
Head of Shared Social Services/CSWO  
Clackmannanshire and Stirling Councils

c.c. Social Services Learning & Development

### Combined references for the full thesis

- Ahmed, E. (2001), 'Shame Management: Regulating Bullying', in Ahmed, E., Harris, N., Braithwaite, J. and Braithwaite, V., eds, *Shame Management through Reintegration*, 209–311. Cambridge: Cambridge University Press.
- Andrews, B. (1998). Methodological and definitional issues in shame research. *Shame: Interpersonal behavior, psychopathology, and culture*, 39-54.
- Andrews, D. A., Bonta, J., & Wormith, S. J. (2006). The recent past and near future of risk/need assessment. *Crime & Delinquency*, 52, 7-27.  
doi:10.1177/0011128705281756
- Andrews, B, Brewin, C.R, Rose, S., Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: the role of shame, anger, and childhood abuse. *Journal of Abnormal Psychology*, 109, 69–73. [doi.org/10.1037/0021-843X.109.1.69](https://doi.org/10.1037/0021-843X.109.1.69)
- Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. *British Journal of Clinical Psychology*, 41(1), 29-42.
- Bennett, D. S., Sullivan, M.W., Lewis, M. (2005). Young children's adjustment as a function of maltreatment, shame, and anger. *Child Maltreatment*, 10 (4), 311–323.  
doi: 10.1177/1077559505278619
- Bennett, D. S., Sullivan, M. W., & Lewis, M. (2010). Neglected children, shame-proneness, and depressive symptoms. *Child maltreatment*, 15(4), 305-314.
- Bernstein, D. P., Nijman, H. L., Karos, K., Keulen-de Vos, M., de Vogel, V., & Lucker, T. P. (2012). Schema therapy for forensic patients with personality disorders: Design

- and preliminary findings of a multicenter randomized clinical trial in the Netherlands. *International Journal of Forensic Mental Health*, 11(4), 312-324.
- Blanchette, K. & Brown, S. L. (2006). *The assessment and treatment of women offenders: An integrative perspective*. Chichester: John Wiley & Sons.
- Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. London, UK: Hogarth Press and the Institute of Psychoanalysis.
- Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation, anxiety, and anger*. London, UK: Hogarth Press and the Institute of Psychoanalysis.
- Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss*. New York, NY: Basic Books.
- Braithwaite, J. (1989). *Crime, Shame and Reintegration*. Cambridge: Cambridge University Press.
- Braithwaite, V., & Braithwaite, J. (2001). Managing tax compliance: The evolution of the Australian Taxation Office compliance model. In *Tax administration in the 21st century*. Prospect Media Pty Ltd.
- Brazão, N., Da Motta, C., Rijo, D., do Céu Salvador, M., Pinto-Gouveia, J., & Ramos, J. (2015). Clinical change in anger, shame, and paranoia after a structured cognitive-behavioral group program: Early findings from a randomized trial with male prison inmates. *Journal of Experimental Criminology*, 11(2), 217-236.
- Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). *Self-report measurement of adult attachment: An integrative overview*. In J. A Simpson & W.S. Rholes (Eds.), *Attachment theory and close relationships* (pp.46-76). New York: Guilford Press.

- Buss, A. H., & Perry, M. (1992). The aggression Questionnaire. *Journal of Personality and Social Psychology*, 63, 452-459.
- Campbell, J. S., & Elison, J. (2005). Shame coping styles and psychopathic personality traits. *Journal of Personality Assessment*, 84, 96-104.
- Carlson, B.E., & Shafer, M.S. (2010). Traumatic histories and stressful life events of incarcerated parents I: Childhood and adult traumatic histories. *The Prison Journal*, 90, 475–493.
- Cassidy, J. (1999). *Handbook of attachment: Theory, research, and clinical applications*. Rough Guides.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.
- Cicchetti, D., Toth, S. L., & Lynch, M. (1995). Bowlby's dream comes full circle: The application of attachment theory to risk and psychopathology. *Advances in Clinical Child Psychology*, 17, 1–75.
- Coie, J.D., & Dodge, K.A. (1998). Aggression and antisocial behavior. In W. Damon & N.Eisenberg (Eds.), *Handbook of child psychology: Social, emotional, and personality development*, Vol. 3 (5<sup>th</sup> ed., pp. 779-862). New York: Wiley.
- Commission on Women Offenders (2012). *Final report 2012*. Edinburgh: Scottish Government. Retrieved 31 March 2013 from <http://www.scotland.gov.uk/About/Review/commissiononwomenoffenders/finalreport-2012>.

- Cook, D. R. (1993). *The Internalized Shame Scale Manual*. Menomonie, WI: Channel Press (available from the author: Rt. 7, Box 270a, Menomonie, WI, 54751).
- Cook, D. R. (1994). *Internalized shame scale: professional manual*. Menomonie, WI: Channel Press.
- Cook, D. R. (1996). Empirical studies of shame and guilt: The internalized shame scale. I D. L. Nathanson (red.), *Knowing feeling: Affect, script and psychotherapy* (ss. 132-165).
- Corston, J. (2007). *The Corston report*. London: Home Office. Retrieved 31 March 2013 from <http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf>
- Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training*, 41, 412-425.
- Covington, S.S., & Bloom, B., E. (2006). Gender Responsive Treatment and Services in Correctional Settings. *Women and Therapy*, 29, (3-4) 9-33. doi:10.1300/J015v29n03\_02
- Cripps, J. E. (1997). *The Association Between the Neutralization of Self-Punishment. Guilt, and Psychopathy Among Extrafamilial Child Molesters* (Doctoral dissertation, Carleton University Ottawa).
- Dearing, R. L., Stuewig, J., & Tangney, J. P. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use. *Addictive behaviors*, 30(7), 1392-1404.

- Dedoose Version **7.0.23**, web application for managing, analyzing, and presenting qualitative and mixed method research data (2016). Los Angeles, CA: SocioCultural Research Consultants, LLC ([www.dedoose.com](http://www.dedoose.com)).
- Deffenbacher, J. L., Oetting, E. R., Thwaites, G. A., Lynch, R. S., Baker, D. A., Stark, R. S., ... & Eiswerth-Cox, L. (1996). State–trait anger theory and the utility of the trait anger scale. *Journal of Counseling Psychology*, 43(2), 131.
- DeHart, D., Lynch, S., Belknap, J., Dass-Brailsford, P., & Green, B. (2014). Life history models of female offending: The roles of serious mental illness and trauma in women's pathways to jail. *Psychology of Women Quarterly*, 38, 138-151. doi: 10.1177/0361684313494357
- Del Rosario, P. M., & White, R. M. (2006). The Internalized Shame Scale: Temporal stability, internal consistency, and principal components analysis. *Personality and Individual Differences*, 41(1), 95-103.
- De Vogel, V., Stam, J., Bouman, Y. H., Ter Horst, P., & Lancel, M. (2016). Violent women: A multicentre study into gender differences in forensic psychiatric patients. *The Journal of Forensic Psychiatry & Psychology*, 27(2), 145-168.
- Dey, I. (1999). *Grounding Grounded Theory Guidelines for Qualitative Inquiry*. San Diego: Academic Press.
- Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). HCR-20 Version 3: Assessing Risk for Violence. User guide. Vancouver, BC: Mental Health Law, and Policy Institute, Simon Fraser University.
- Dyer, K., Dorahy, M., Corry, M., Black, R., Matheson, L., Coles, H., . . . Middleton, W. (2016). Comparing Shame in Clinical and Nonclinical Populations:

Preliminary Findings. *Psychological Trauma: Theory, Research, Practice, and Policy*, Psychological Trauma: Theory, Research, Practice, and Policy, 2016.

Easton, P., Entwistle, V. A., & Williams, B. (2010). Health in the 'hidden population' of people with low literacy. A systematic review of the literature. *BMC public health*, 10(1), 459.

Elison, J. (2005). Shame and guilt: A hundred years of apples and oranges. *New Ideas in Psychology*, 23(1), 5-32.

Farmer, E., & Andrews, B. (2009). Shameless yet angry: shame and its relationship to anger in male young offenders and undergraduate controls. *The Journal of Forensic Psychiatry & Psychology*, 20(1), 48-65.

Fazel, S., Bains, P., & Doll, H. (2006). Substance abuse and dependence in prisoners: a systematic review. *Addiction*, 101, 181-191.

Fazel, S., Seewald, K. (2012). Severe mental illness in 33,588 prisoners worldwide: systematic review and meta-regression analysis. *The British Journal of Psychiatry: the Journal of Mental Science*, 200 (5), 364-373. doi: 10.1192/bjp.bp.111.096370

Feiring, C., Taska, L., & Lewis, M. (1996). A process model for understanding adaptation to sexual abuse: The role of shame in defining stigmatization. *Child abuse & neglect*, 20(8), 767-782.

Fergus T. A., Valentiner, D. P., McGrath P. B., Jencius, S. (2010). Shame- and guilt-proneness: Relationships with anxiety disorder symptoms in a clinical sample. *Journal of Anxiety Disorders*, 24, 811–815.



- Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2009). Lifetime assessment of poly-victimization in a national sample of children and youth. *Child abuse & neglect*, 33(7), 403-411.
- Friedrich, W. N. (2002). *Psychological assessment of sexually abused children and their families*. Sage.
- Gelsthorpe, L., Sharpe, G., & Roberts, J. (2007). *Provision for Women Offenders in the Community*. London: Fawcett Society.
- Gilbert, P. (1992). *Depression. The Evolution of Powerlessness*. London, New York: Routledge.
- Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology*, 70(2), 113-147.
- Gilbert, P. (1998). What is shame? Some core issues and controversies. In *Shame: Interpersonal behaviour, psychopathology and culture* (pp. 3–36). New York, NY: Oxford University Press.
- Gilbert, P. (2002). Evolutionary approaches to psychopathology and cognitive therapy. *Journal of Cognitive Psychotherapy*, 16(3), 263-294.
- Gilbert, P., & Andrews, B. (1998). *Shame: Interpersonal behavior, psychopathology, and culture*. Oxford University Press on Demand.
- Gilbert, P., & McGuire, M. T. (1998). Shame, status, and social roles: Psychobiology and evolution. In *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 99-125). New York, NY: Oxford University Press.
- Gilbert, P., & Miles, J. (2014). *Body shame: Conceptualisation, research and treatment*. Suffolk, UK: Routledge.

- Gilbert, P., Pehl, J., & Allan, S. (1994). The phenomenology of shame and guilt: An empirical investigation. *British Journal of Medical Psychology*, 67(1), 23-36.
- Gilfus, M. E. (1993). From victims to survivors to offenders: Women's routes of entry and immersion into street crime. *Women & Criminal Justice*, 4(1), 63-89.
- Gilligan, J. (1996). Exploring shame in special settings: A psychotherapeutic study. In *Forensic psychotherapy: Crime, Psychodynamics and the offender patient* (Vol 2, pp. 475-490). London: Jessica Kingsley Publisher.
- Gilligan, J. (2000). Punishment and violence: Is the criminal law based on one huge mistake?. *Social Research*, 745-772.
- Gilligan, J. (2003). Shame, guilt, and violence. *Social Research*, 1149-1180.
- Giner-Sorolla, R., Piazza, J., & Espinosa, P. (2011). What do the TOSCA guilt and shame scales really measure: Affect or action?. *Personality and Individual Differences*, 51(4), 445-450.
- Guest, G., Bunce, A. & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18, 59–82.
- Goss, K., Gilbert, P., & Allan, S. (1994). An exploration of shame measures—I: The other as Shamer scale. *Personality and Individual differences*, 17(5), 713-717.
- Goss, K., & Allan, S. (2009). Shame, pride and eating disorders. *Clinical Psychology & Psychotherapy*, 16, 303–316.

- Hannah-Moffat, K. (2005) Criminogenic needs and the transformative risk subject Hybridizations of risk/need in penalty. *Punishment & Society*, 7 (1), 29-51. doi: 10.1177/1462474505048132
- Hanson, R. K. (1996, November). Coping with culpability. Paper presented at the meeting of the Association for the Treatment of Sexual Abusers, Chicago.
- Hanson, R. K., & Tangney, J. P. (1996). The test of self-conscious affect—socially deviant populations (TOSCA-SD). *Unpublished corrections research, Department of the Solicitor General of Canada, Ottawa, Ontario, Canada.*
- Harder, D. W., & Lewis, S. J. (1987). The assessment of shame and guilt. *Advances in personality assessment*, 6, 89-114.
- Harder, D. W., Cutler, L., & Rockart, L. (1992). Assessment of shame and guilt and their relationships to psychopathology. *Journal of personality assessment*, 59(3), 584-604.
- Harder, D. W., Rockart, L., & Cutler, L. (1993). Additional validity evidence for the harder personal feelings questionnaire-2 (PFQ2): A measure of shame and guilt proneness. *Journal of clinical psychology*, 49(3), 345-348.
- Harder, D. H., & Zalma, A. (1990). Two promising shame and guilt scales: A construct validity comparison. *Journal of personality assessment*, 55(3-4), 729-745.
- Harper, F. W., Austin, A. G., Cercone, J. J., & Arias, I. (2005). The role of shame, anger, and affect regulation in men's perpetration of psychological abuse in dating relationships. *Journal of Interpersonal Violence*, 20(12), 1648-1662.

- Harper, F.W.K., Arias, I. (2004). The role of shame in predicting adult anger and depressive symptoms among victims of child psychological maltreatment. *Journal of Family Violence*, 19 (6), 367–375. doi: 10.1007/s10896-004-0681-x
- Harris, N. (2003) ‘Reassessing the Dimensionality of the Moral Emotions’, *British Journal of Psychology*, 94: 457 – 73.
- Harris, N. (2006). ‘Reintegrative Shaming, Shame and Criminal Justice’. *Journal of Social Issues*, 62, 327 – 46.
- Hassan, L., Frisher, M., Senior, J., Tully, M., Webb, R., While, D., & Shaw, J. (2014). A cross-sectional prevalence survey of psychotropic medication prescribing patterns in prisons in England.
- Hedderman, C., Gunby, C. & Shelton, N. (2011). What women want: The importance of qualitative approaches in evaluating work with women offenders. *Criminology and Criminal Justice*, 11, 3-19.
- Hejdenberg, J., & Andrews, B. (2011). The relationship between shame and different types of anger: A theory-based investigation. *Personality and Individual Differences*, 50(8), 1278-1282.
- HM Inspectorate of Prisons (2007). HMP and YOI Cornton Vale, 19-20.
- Hoglund, C. L., & Nicholas, K. B. (1995). Shame, guilt, and anger in college students exposed to abusive family environments. *Journal of Family Violence*, 10, 141–157.

- Hollin, C. R. & Palmer, E. J. (2006). Criminogenic need and women offenders: A critique of the literature. *Legal and Criminological Psychology*, 11, 179-195.
- Hosser, D., Windzio, M., & Greve, W. (2008). Guilt and Shame as Predictors of Recidivism A Longitudinal Study With Young Prisoners. *Criminal Justice and Behavior*, 35(1), 138-152.
- Howells, K. (2004). Anger and its link to Violent Offending. *Journal of Psychiatry, Psychology and Law*, 11 (2), 189-196. doi:10.1375/pplt.2004.11.2.189
- Izard, C. E. (1993). *The Differential Emotions Scale: DES IV-A;[a Method of Measuring the Meaning of Subjective Experience of Discrete Emotions]*. University of Delaware.
- Izard C. E. (1971) *The Face of Emotion*. Appleton-Century-Crofts: New York.
- Izard, C. E., Libero, D. Z., Putnam, P., & Haynes, O. M. (1993). Stability of emotion experiences and their relations to traits of personality. *Journal of personality and social psychology*, 64(5), 847.
- Jackson, A. (2009). The impact of restorative justice on the development of guilt, shame, and empathy among participants in a victim impact training program. *Victims & Offenders*, 4(1), 1-24.
- Jackson, A. L., & Bonacker, N. (2006). The effect of victim impact training programs on the development of guilt, shame and empathy among offenders. *International Review of Victimology*, 13(3), 301-324.
- Kaufman, G. (1989) *The Psychology of Shame*. New York: Springer.

- Keen, S. (2008). *Perceived Social Rank, Social expectation, shame and general emotionality within psychopathy (Doctorate thesis, University College London, London, England)*. Retrieved from <http://discovery.ucl.ac.uk/1444243/1/U591545.pdf>
- Kreis, M. K., Gillings, K., Svanberg, J., & Schwannauer, M. (2016). Relational Pathways to Substance Misuse and Drug-Related Offending in Women: The Role of Trauma, Insecure Attachment, and Shame. *International Journal of Forensic Mental Health, 15*(1), 35-47.
- Laithwaite, H., O'Hanlon, M., Collins, P., Doyle, P., Abraham, L., Porter, S., & Gumley, A. (2009). Recovery after psychosis (RAP): A compassion focused programme for individuals residing in high security settings. *Behavioural and Cognitive Psychotherapy, 37*(05), 511-526.
- Lawlor, E., Nicholls, J., & Sanfilippo, L. (2008). *Unlocking Value: How we all benefit from investing in alternatives to prison for women offenders*. new economics foundation.
- Leach, C., Cidam, A., & Smith, Eliot R. (2015). When Is Shame Linked to Constructive Approach Orientation? A Meta-Analysis. *Journal of Personality and Social Psychology, 109*(6), 983-1002.
- Lewis, H. B. (1971). *Shame and Guilt in Neurosis*. New York (International Universities Press) 1971.
- Lewis, H.B. (1986) The role of shame in depression. In M. Rutter, C.E. Izard & P.B. Read (Eds.) *Depression in Young People: Developmental and Clinical Perspectives*. NY: Guilford Press.

- Light, M., Grant, E., & Hopkins, K. (2013). *Gender differences in substance misuse and mental health amongst prisoners: Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners*. London: Ministry of Justice.
- Lowinger, T., & Solomon, Z. (2004). PTSD, guilt, and shame among reckless drivers. *Journal of Loss and Trauma*, 9(4), 327-344.
- Lynch, S. M., DeHart, D. D., Belknap, J., & Green, B. (2013). Women's pathways to jail: Examining mental health, trauma, and substance use. *NCJ*, 241045.
- McClellan, C. S., Farabee, D., & Crouch, B. M. (1997). Early victimization, drug use, and criminality: A comparison of male and female prisoners. *Criminal Justice and Behavior*, 24, 455-476. doi: 10.1177/0093854897024004004
- Messina, N., & Grella, C. (2006). Childhood trauma and women's health outcomes: A California prison population. *The American Journal of Public Health*, 96(10), 1842-1848.
- Milligan, R. J., & Andrews, B. (2005). Suicidal and other self-harming behaviour in offender women: The role of shame, anger and childhood abuse. *Legal and Criminological Psychology*, 10(1), 13-25.
- Morrison, D., & Gilbert, P. (2001). Social rank, shame and anger in primary and secondary psychopaths. *Journal of Forensic Psychiatry*, 12(2), 330-356.
- Murphy, K., & Harris, N. (2007). Shaming, shame and recidivism a test of reintegrative shaming theory in the white-collar crime context. *British Journal of Criminology*, 47(6), 900-917.

- Murphy, K., & Helmer, I. (2013). Testing the importance of forgiveness for reducing repeat offending. *Australian & New Zealand Journal of Criminology*, 46(1), 138-156.
- Nathanson, D. L. (1992). *Shame and pride: Affect, sex, and the birth of the Self*. New York:
- O'Brien, M., Mortimer, L., Singleton, N., & Meltzer, H. (2001). *Psychiatric morbidity among women prisoners in England and Wales*. London: Office for National Statistics.
- Perez, M. A. (2005). *The cycle of violence: Shame and attachment issues among violent perpetrators (Master's thesis, University of California, Long Beach, USA)*. Retrieved from <http://search.proquest.com.ezproxy.is.ed.ac.uk/docview/305365211/>
- Parke, R.D., & Slaby, R. G. (1983). The development of aggression. In P. Mussen & M. Hetherington (Eds.), *Handbook of child psychology: Socialization, personality and social development*, Vol. 4 (4<sup>th</sup> ed., pp. 547-641). New York: Wiley.
- Paulhus, D. L., Robins, R. W., Trzesniewski, K.H., & Tracy, J.L. (2004). Two replicable suppressor situations in personality research. *Multivariate Behavioral Research*, 39, 303–328. [doi.org/10.1207/s15327906mbr3902\\_7](https://doi.org/10.1207/s15327906mbr3902_7)
- Pinto-Gouveia, J., & Matos, M. (2011). Can shame memories become a key to identity? The centrality of shame memories predicts psychopathology. *Applied Cognitive Psychology*, 25, 281–290. doi:10.1002/acp.1689



- Retzinger, S. M., & Scheff, T. J. (1996). Strategy for community conferences: Emotions and social bonds. *Restorative justice: International perspectives*, 315-36.
- Roseman, C. P., Ritchie, M., & Laux, J. M. (2009). A restorative justice approach to empathy development in sex offenders: An exploratory study. *Journal of Addictions & Offender Counseling*, 29(2), 96-109.
- Scottish Government (2008). *Out of Sight: Severe and Enduring Mental Health Problems in Scotland's Prisons*. Edinburgh: Scottish Government.
- Scottish Government (2011). *Statistical Release Crime and Justice Series: Scottish prison population projections: 2010-11 to 2019-20*. Edinburgh: Scottish Government.
- Scottish Government. (2015). New plans for women in custody announced. Retrieved from <https://news.gov.scot/news/new-plans-for-women-in-custody-announced>
- Shanahan, S., Jones, J., & Thomas-Peter, B. (2011). Are you looking at me, or am I? Anger, aggression, shame and self-worth in violent individuals. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 29(2), 77-91.
- Singleton, N., Meltzer, H., Gatward, R., Coid, J. & Deasy, D. (1998). *Psychiatric morbidity among prisoners: summary report*. London: Office for National Statistics.
- Sklar, M., Groessl, E. J., O'Connell, M., Davidson, L., & Aarons, G. A. (2013). Instruments for measuring mental health recovery: a systematic review. *Clinical psychology review*, 33(8), 1082-1095.

- Sorbello, L., Eccleston, L., Ward, T., & Jones, R. (2002). Treatment needs of female offenders: a review. *Australian Psychologist*, 37, 3, 198-205. doi:10.1080/00050060210001706876
- Spice, A., Viljoen, J. L., Douglas, K. S., & Hart, S. D. (2015). Remorse, psychopathology, and psychopathy among adolescent offenders. *Law and human behavior*, 39(5), 451.
- Stearns, P. (1995) Emotion. In R. Harre & P. Stearns (Eds.) *Discursive Psychology in Practice*. London: Sage.
- Stuewig, J., & McCloskey, L. A. (2005). The relation of child maltreatment to shame and guilt among adolescents: Psychological routes to depression and delinquency. *Child Maltreatment*, 10(4), 324-336.
- Stuewig, J., Tangney, J. P., Heigel, C., Harty, L., & McCloskey, L. (2010). Shaming, blaming, and maiming: Functional links among the moral emotions, externalization of blame, and aggression. *Journal of Research in Personality*, 44(1), 91-102.
- Stuewig, J., Tangney, J. P., Mashek, D., Forkner, P., & Dearing, R. (2009). The moral emotions, alcohol dependence, and HIV risk behavior in an incarcerated sample. *Substance use & misuse*, 44(4), 449-471.
- Styron, T., & Janoff-Bulman, R. (1997). Childhood attachment and abuse: Long-term effects on adult attachment, depression, and conflict resolution. *Child abuse & neglect*, 21(10), 1015-1023.
- Tangney, J. P. (1991). Moral affect: The good, the bad, and the ugly. *Journal of Personality and Social Psychology*, 61, 598-607.

- Tangney, J.P. (1992) Situational determinants of shame and guilt in young adulthood. *Personality and Social Psychological Bulletin*, 18, 2, 199-206.
- Tangney, J.P., & Dearing, R. (2002). Shame and Guilt. New York: Guilford.
- Tangney, J.P., Dearing, R., Wagner, P.E., & Gramzow, R. (2000). *The Test of Self-Conscious Affect. 3 (TOSCA-3)*. Fairfax, VA: George Mason University.
- Tangney, J. P., & Fischer, K. W. (Eds.). (1995). Self-conscious emotions: The psychology of shame, guilt, embarrassment and pride. New York, NY: Guilford Press.
- Tangney, J.P., Miller, R.S., Flicker, L, & Barlow, D.H. (1996) Are shame, guilt and embarrassment distinct emotions? *Journal of Pers.and Social Psychology*, 70, 6, 1256-1269.
- Tangney, J., Stuewig, J., & Hafez, L. (2011). Shame, guilt, and remorse: Implications for offender populations. *Journal of Forensic Psychiatry & Psychology*, 22(5), 706-723.
- Tangney, J. P., Stuewig, J., & Martinez, A. G. (2014). Two faces of shame the roles of shame and guilt in predicting recidivism. *Psychological science*, 25(3), 799-805.
- Tangney, J. P., Stuewig, J., & Martinez, A.G. (2014). Two Faces of Shame: The Roles of Shame and Guilt in Predicting Recidivism. *Psychological Science*, 25, 3, 799-805. doi: 10.1177/0956797613508790
- Tangney, J. P., Stuewig, J., Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual Review of Psychology*, 58, 345–372

- Tangney, J. P., Stuewig, J., Mashek, D., & Hastings, M. (2011). Assessing jail inmates' proneness to shame and guilt: Feeling bad about the behavior or the self?. *Criminal justice and behavior*, 0093854811405762.
- Tangney, J. P., Wagner, P., Fletcher, C., & Gramzow, R. (1992). Shamed into anger? The relation of shame and guilt to anger and self-reported aggression. *Journal of personality and social psychology*, 62(4), 669.
- Tangney, J.P., Wagner, P. & Gramzow, R. (1992) Proneness to shame, proneness to guilt, and psychopathology. *Journal of Abnormal Psychology*, 101, 3, 469-478.
- Tangney, J. P., Wagner, P., & Gramzow, R. (1989). *The Test of Self-Conscious Affect*. Fairfax, VA: George Mason University.
- Tedeschi, J., & Felson, R. B. (1994). Violence, aggression, and coercive actions. Washington, DC, US: American Psychological Association. doi: [org/10.1037/10160-000](https://doi.org/10.1037/10160-000)
- Terwee, C. B., Bot, S. D., de Boer, M. R., van der Windt, D. A., Knol, D. L., Dekker, J., ... & de Vet, H. C. (2007). Quality criteria were proposed for measurement properties of health status questionnaires. *Journal of clinical epidemiology*, 60(1), 34-42.
- Tilghman-Osborne, C., Cole, D. A., & Felton, J. W. (2010). Definition and measurement of guilt: Implications for clinical research and practice. *Clinical Psychology Review*, 30(5), 536-546.
- Tompkins, S. S. (1963). Affect, imagery, consciousness: II. The Negative Affects.

- Velotti, P., Garofalo, C., Bottazzi, F., & Caretti, V. (2016). Faces of shame: implications for self-esteem, emotion regulation, aggression, and well-being. *The Journal of Psychology, 151*(2), 171-184.
- Velotti, P., Elison, J., & Garofalo, C. (2014). Shame and aggression: Different trajectories and implications. *Aggression and Violent Behavior, 19*(4), 454-461.
- Walmsley, R. (2015). World female imprisonment list (Women and girls in penal institutions, including pre-trial detainees/remand prisoners). *World female imprisonment list (Women and girls in penal institutions, including pre-trial detainees/remand prisoners)*.
- Winham, K. M., Engstrom, M., Golder, S., Renn, T., Higgins, G. E., & Logan, T. K. (2015). Childhood victimization, attachment, psychological distress, and substance use among women on probation and parole. *American Journal of Orthopsychiatry, 85*(2), 145.
- Wright, K., & Gudjonsson, G. H. (2007). The development of a scale for measuring offence-related feelings of shame and guilt. *The Journal of Forensic Psychiatry & Psychology, 18*(3), 307-316.
- Wright, K., Gudjonsson, G. H., & Young, S. (2008). An investigation of the relationship between anger and offence-related shame and guilt. *Psychology, Crime & Law, 14*, 415- 423.
- Ward, T., Hudson, S. M., & Marshall, W. L. (1994). The abstinence violation effect in child molesters. *Behaviour Research and Therapy, 32*(4), 431-437.

- Wright, K., & Gudjonsson, G. H. (2007). The development of a scale for measuring offence-related feelings of shame and guilt. *The Journal of Forensic Psychiatry & Psychology*, 18(3), 307-316.
- Wright, K., Gudjonsson, G. H., & Young, S. (2008). An investigation of the relationship between anger and offence-related shame and guilt. *Psychology, Crime & Law*, 14(5), 415-423.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. Guilford Press.
- Youngstrom, E. A., & Green, K. W. (2003). Reliability generalization of self-report of emotions when using the Differential Emotions Scale. *Educational and Psychological Measurement*, 63(2), 279-295.
- Zlotnick, C., Clarke, J. G., Friedmann, P. D., Roberts, M. B., Sacks, S., & Melnick, G. (2008). Gender differences in comorbid disorders among offenders in prison substance abuse treatment programs. *Behavioral sciences & the law*, 26(4), 403.